Strengthening public health contributions to alcohol licensing processes

INSIGHTS FROM THE PUBLIC HEALTH & ALCOHOL LICENSING (PHAL) STUDY

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**Authors**

Joanna Reynolds¹, Michael McGrath¹, Jessica Engen¹, Ghazaleh Pashmi², Matthew Andrews², Matt Egan¹, Jin Lim³, Karen Lock¹

¹ Faculty of Public Health & Policy, London School of Hygiene & Tropical Medicine

² Safe Sociable London Partnership

³ Southwark Council, and London Healthy Place Network

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CIP – Cumulative impact policy
CIZ – Cumulative impact zone
GLA – Greater London Authority
JSNA – Joint Strategic Needs Assessment
LA – Local authority
LAAA – Local Alcohol Action Area
PH – Public health
RA – Responsible authority
RtS – Reducing the Strength
SLP – Statement of Licensing Policy
SPA – Special policy area
SSLP – Safe Sociable London Partnership
TEN – Temporary event notice
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Foreword

By Dr. Jin Lim and Dr. Fiona Wright, Joint Chairs of London Healthy Place Network

Alcohol misuse is an important factor in poorer health. It is a leading cause of hospital admission, as either a consequence of acute alcohol intoxication or of alcohol misuse over time. There is also a health inequalities dimension, with aspects of alcohol misuse affecting the most vulnerable groups and the most deprived parts of the country – both in terms of the direct impact on health and the related anti-social behavior and violence. Good alcohol licensing practice is an important part of how we can address alcohol misuse.

This report, based on a study of London boroughs carried out by the London School of Hygiene & Tropical Medicine is very much welcomed. Public health can and do play an important and valued role in the alcohol licensing process. Directors of Public Health, in their designated ‘responsible authority’ role, are able to help shape alcohol availability and to reduce alcohol related harms. The report highlights:

- The approaches taken by public health teams;
- The range of licensing conditions used, illustrated with examples;
- Case studies of working practice.

It also makes recommendations on how the public health approach can be strengthened to be more effective.

This research described in this report makes clear that for many public health teams, alcohol licensing is an important aspect of their ‘health in all policies’ work. Some boroughs have used the Safe Sociable London Partnership toolkit whereas others have created or adapted an approach to suit local circumstances. By making use of their public health skills to systematically consider data and evidence, the teams have made important contributions to licensing decisions and helped to shape healthier places.

For a relatively low investment in terms of public health staff time on alcohol licensing, many departments are demonstrating very visible outcomes and building strong alliances within their councils. Moving forward, it will be important that public health input to this agenda is appropriately resourced.
We commend this report for careful consideration of public health colleagues and others. Lastly, we would like to thank everyone who have given up their time to participate in this study.

Dr. Jin Lim
Consultant in Public Health
Southwark

Dr. Fiona Wright
Consultant in Public Health
Barking & Dagenham, Greater London Authority

Joint Chairs of London Healthy Place Network
EXECUTIVE SUMMARY

In the past five years, the opportunities for public health teams in England to help shape the availability of alcohol and to reduce alcohol-related harms via the alcohol licensing process in local government have increased through the repositioning of public health in local authorities, and the designation of Directors of Public Health as ‘responsible authorities’ for licensing.

However, the extent to which public health (PH) practitioners feel able to enact this role and how they can effectively influence alcohol licensing decision making varies widely. This report summarises findings from a study of PH practitioners’ contributions to alcohol licensing in local authorities (LAs) in London, and makes recommendations for strengthening the public health role in licensing that is relevant to practitioners nationally.

The PHAL study

The Public Health & Alcohol Licensing study was conducted between July 2016 and March 2018 across 24 out of 33 LAs in Greater London, to explore perceptions and experiences of the public health alcohol licensing role, and its influence on alcohol licensing decision making. A range of stakeholders, including PH practitioners, other responsible authority (RA) practitioners and licensing stakeholders were engaged through a study involving ethnographic observations, a survey, focus groups, interviews and analysis of routine data.

Key findings: varied approaches, capacities and impact

Across the 24 London local authorities who participated in the study, a wide range of experiences of the public health contribution to alcohol licensing was observed. This included:

- Varied workloads in terms of numbers of applications received by public health teams, ranging from 0 to > 25 per month.
- Different levels of capacity in public health teams to undertake licensing work, ranging from none at all to > 9 hours per week.
- Screening licence applications to assess need for public health action often rested on priorities relating to the availability of alcohol (such as late hours of sale) and protecting vulnerable groups (such as street drinkers or people in deprived areas).
- Among those more active in alcohol licensing, approaches adopted for taking action on licence applications varied but often involved attempts to negotiate with applicants either before or after submitting a full representation.
- Multiple types of data and information were used across areas to support public health representations, but often included one or more of: crime and ambulance statistics at postcode level; local or national research evidence; local alcohol policies eg Statement of Licensing Policy (SLP); and data on costs of treating alcohol-related conditions.
• While some PH practitioners felt they did not have much influence over licensing sub-committee decision making, some level of impact was recorded for 84% of applications on which PH practitioners took action (negotiation and/or representation).

**Key findings: factors influencing public health contributions**

Across the study, several factors were identified as shaping the extent to which PH practitioners contributed to the alcohol licensing process, and perceptions of their influence over decision making. These were:

• **The status of public health as a responsible authority.** Without a health licensing objective, many stakeholders felt public health was limited in its licensing role. However, some PH practitioners demonstrated how it is possible to build up their influence over time without specific health objectives.

• **Relationships with other responsible authorities.** Regular engagement between public health and other RAs, through meetings, shared roles or co-located working seems to shape perceptions of the value and influence of public health licensing contributions.

• **What evidence counts in the decision-making process.** Many PH practitioners were concerned about having their representations challenged in licensing hearings. There were often tensions between the population level perspective of public health and expectations for premises-specific evidence for licensing decision making. However, some PH practitioners illustrated effective use of different information, including a toolkit developed by Safe Sociable London Partnership, data from Greater London Authority’s ‘SafeStats’ database and other sources.

• **Contributing to broader licensing policy,** such as the SLP or cumulative impact policies was viewed as a valuable way for public health to influence licensing. In turn, PH practitioners described using these policies as resources to support representations against applications.

• **Resources and capacity** were inevitable factors shaping the ability of PH practitioners to undertake licensing work, reflecting competing priorities within public health and the broader council, in the current climate of austerity, and loss of institutional knowledge with staff turnover.

**Recommendations:**

We identified steps that PH practitioners can take to strengthen their alcohol licensing contributions, reflecting existing levels of engagement:

1. Engage regularly with other RAs, through meetings or co-located working, and in development of licensing policy.

2. Build up a database of relevant evidence and resources from both local and national sources.
3. Identify ways to share best practice and examples of licensing work with PH practitioners from other areas.

4. Improve communication by presenting evidence in public health representations clearly and succinctly, suitable for the non-specialist.

The key steps to strengthening public health contributions to alcohol licensing, based on the PHAL study findings, are illustrated in an infographic. The full-size graphic is presented in the report below, and can be downloaded from: [http://sphr.lshtm.ac.uk/phal/](http://sphr.lshtm.ac.uk/phal/)

Results from the study are also presented in a paper published in the *Journal of Public Health*:

Reynolds, J; McGrath, M; Engen, J; … & Lock, K. (2018). ‘A true partner around the table?’ Perceptions of how to strengthen public health’s contributions to the alcohol licensing process.

*Journal of Public Health*, [https://doi.org/10.1093/pubmed/fdy093](https://doi.org/10.1093/pubmed/fdy093)
1 Background and Study Overview

1.1 The role of public health in alcohol licensing

While public health has had a long-standing interest in addressing the harmful consequences of alcohol consumption, the profession has only recently held a formal role in local authority alcohol licensing processes. Following revisions to the Licensing Act for England and Wales (The Licensing Act 2003), the Police Reform and Social Responsibility Act (Police Reform and Social Responsibility Act 2011) saw health authorities (and specifically Directors of Public Health) in England designated a statutory role as a ‘responsible authority’ (RA) in the licensing process. This gave them the right to review and comment on applications for alcohol licences alongside other professions with a more established licensing remit, including trading standards, environmental protection, children’s services, licensing, police and others. The re-location of public health teams to local authorities in England in 2013 provided further opportunities for closer integration of public health agendas and the statutory work of local government (Phillips and Green 2015), including alcohol licensing. Public health now has a mechanism to review alcohol licence applications, make representations (or objections) against them as appropriate, and offer recommendations to licensing sub-committees for how – and whether – licences to sell alcohol should be granted (Andrews, Pashmi et al. 2014).

They also have increased opportunity to work with other RAs to shape local alcohol policies, such as the Statement of Licensing Policy of each local authority (renewed every five years), or area-specific policies, such as Cumulative Impact Policies (Egan, Brennan et al. 2016, Sharpe, Poots et al. 2017).

See Appendix A for a glossary of key alcohol policies and programmes identified in this report.

These changes present good opportunities for public health to contribute more to alcohol licensing processes and through this, to influence the local alcohol environment and its related health and social harms (Andrews, Pashmi et al. 2014). Under the Licensing Act in England and Wales, designated RAs (now including Directors of Public Health) can make representations to demonstrate if proposed or existing licensed premises undermines one or more of the four licensing objectives:

i. prevention of crime and disorder,
ii. protection of public safety,
iii. prevention of public nuisance and,
iv. protection of children from harm.

However, none of these objectives are explicitly focused on health, and consequently there have been concerns about how public health practitioners in England can frame representations against
licence applications, and the extent to which they can influence licensing decision making to address alcohol-related health harms (Martineau, Graff et al. 2014, Public Health England 2017).

Furthermore, experiences in Scotland, where there is a fifth licensing objective to promote and protect public health, have indicated continuing challenges for public health in communicating evidence of health impacts and demonstrating links between individual licensed premises and population health harms (Fitzgerald, Nicholls et al. 2017). This raises questions of how public health in England can better engage in alcohol licensing work in local authorities, to make effective contributions that help reduce health and social harms related to the local sale of alcohol.

Focus of this report:

This report summarises findings from a study exploring the range and outcomes of public health contributions to alcohol licensing across local authorities in London, and makes recommendations for how practitioners can strengthen the position and contribution of public health in licensing work. The research focused on Greater London, in part because the original study objectives included an evaluation of a toolkit by Safe Sociable London Partnership (SSLP), designed to support public health practitioners in London boroughs in their alcohol licensing work (see Box 1 below).

Box 1 Summary of toolkit for public health licensing work developed by Safe Sociable London Partnership

**Safe Sociable London Partnership** developed a package of resources to guide public health practitioners in screening and taking action on alcohol licence applications. The toolkit, commissioned by public health teams in 13 local authorities in London since 2013, included:

- a training session for public health and other RAs
- tailored information resources
- templates for screening applications and writing representations
- borough-specific data sheets connected to London crime and ambulance data, produced by Greater London Authority (the ‘SafeStats’ database).
- follow-up support.

For more information see: [https://www.safesociable.com/](https://www.safesociable.com/)
Structure of the report:

First, we briefly describe the Public Health and Alcohol Licensing (PHAL) study, its aims, methods and study findings, with supporting case examples. The findings present a comparative picture of alcohol licensing work undertaken currently by public health practitioners across different London local authorities, and key influences on public health licensing practice and its outcomes. Finally, we present a series of recommendations for strengthening public health contributions, tailored to the current public health practice in different local authorities. We also offer suggestions for other local authority stakeholders to consider how best to work with public health to strengthen the licensing process overall.

1.2 The Public Health and Alcohol Licensing study – aims

The Public Health and Alcohol Licensing (PHAL) study is funded through the NIHR School for Public Health Research, as part of the Public Health Practitioner Evaluation Scheme in collaboration with Public Health England. The study was conducted by a team of collaborators from London School of Hygiene & Tropical Medicine, Safe Sociable London Partnership (SSLP), Southwark Council Public Health, and on behalf of London Healthy Place Network. The study ran from September 2016 to March 2018, and aimed to:

➢ Explore the range of influences on public health (PH) practitioners’ contributions to alcohol licensing processes;
➢ Examine and evaluate the use of a toolkit (authored by SSLP) to support PH practitioners to make representations against alcohol licence applications; and
➢ Identify ways to strengthen PH contributions to alcohol licensing processes.

1.3 PHAL study context, methods and sample

This study focused on public health practitioners in the 33 local authorities across Greater London (including City of London Corporation). Through the study, we have connected directly with most of these local authorities, engaging primarily with public health practitioners doing alcohol licensing work, but also with practitioners from other responsible authorities (RAs), and other stakeholders with an interest in alcohol licensing.

We used five different methods to understand how PH practitioners conduct alcohol licensing work, to explore what challenges they face, and to identify how to strengthen the effectiveness of their contributions. These included:
Data were collected between September 2016 and December 2017, and 24 out of 33 London LAs were represented in one or more stages of the research process. We actively sought to engage with LAs who had access to the SSLP toolkit as well as those who did not, to explore how the toolkit was being used in public health licensing work. See the table in Appendix B for a summary of each method and the sample of participants and types of LA included for each (the names and details of all LAs have been anonymised). Qualitative data from the ethnographic observations, focus groups and interviews were analysed thematically, and the quantitative data from the survey and routine data were analysed using descriptive statistics.

1.4 Practitioner involvement

Reflecting the practitioner-oriented origins of this study, practitioners have been involved in shaping the design of the study and in helping to identify appropriate ways to share its findings. In addition to collaborators’ inputs throughout the study, practitioners from several of the ethnographic field sites helped develop the survey by piloting a draft version of the questionnaire and providing useful feedback on the scope and detail of its questions. The final version of the survey was directly informed by the inputs of these practitioners.
We also held practitioner workshops in September 2017 and March 2018 to share findings from the study and to invite discussion around the types of information and formats of study outputs that practitioners (from public health and other local authority departments) would find most useful for informing their practice. These workshops were extremely valuable for shaping the study content and final study outputs. We are grateful to all practitioners who have helped shape the study and its outputs.
From the different components of the PHAL study, it was clear that there is great variety across local authorities in London in terms of the amount of involvement of public health teams in alcohol licensing processes, the approaches taken and perceptions of influence over licensing decision making. Understanding more about what is happening in different LAs may be useful for practitioners across the UK to position themselves, and to think about other approaches they might be able to take to strengthen public health contributions to alcohol licensing.

2.1 Variations in public health workload and contributions

The survey of public health practitioners across LAs in Greater London was valuable for understanding the range of input to alcohol licensing work across different public health teams. Survey respondents were the public health practitioner responsible for alcohol licensing work in each LA. Eighteen LAs were represented in the survey; attempts to recruit all 33 London LAs revealed a lack of current capacity for alcohol licensing work in some LA public health teams.

Recruitment for survey:

Out of the 33 London LAs, a named public health contact responsible for alcohol licensing work was identified in 28. Of these 28 LAs, a PH practitioner from 18 completed the survey and 10 did not. Of the remaining five LAs, contact was made with three public health teams who explained they did not undertake any alcohol licensing work and did not feel able to complete the survey. It was not possible to make contact with appropriate people in the other two LAs, and for one, a member of the licensing team stated they did not send licence applications to public health. The recruitment process indicates that in several LAs in London there did not appear to be any established process in public health teams for regular involvement in alcohol licensing work at the time of the survey (March to May 2017).

Survey results: Public health workload and capacity

PH practitioners across London LAs indicated a range of levels of licensing workload, in terms of the average number of applications received per month (between 0 and >21) and the average number of person-hours spent on licensing work per week, (between 0-2 hours to > 9 hours). See Table 1 for a summary of licensing workload.
We analysed nine months of routinely collected data from public health teams in five LAs on the number and type of alcohol licence applications they reviewed and actions taken. The average number of licence applications received per month by the public health team in each LA ranged from 5 to 21, which supports the survey results.

The survey results also indicated that practitioners have different levels of capacity to take action on licence applications. While almost all respondents take some action on a regular basis, one stated they never take any action at all, and a few others rarely take action other than screening applications. See Figure 1 for a breakdown of the type and frequency of actions taken (from no action to a representation heard at the licensing sub-committee) reported by respondents.
2.2 Different approaches taken to licensing work

From across the study, it emerged that PH practitioners in different LAs have a range of ways of approaching alcohol licensing work and of taking action on licence applications. Ethnographic observations of PH practitioners’ licensing work were conducted in eight LAs which were selected due to their levels of public health licensing activity, and to compare between LAs with and without access to the toolkit developed by SSLP. The observation of practitioners’ work in these eight LAs over several months helped generate detailed understanding of approaches taken, supplemented through the focus group discussions. Furthermore, it was through these observations that it became apparent that an evaluation of how the SSLP toolkit was being used by PH practitioners and its impact on alcohol licensing work, as intended in the original study aims, was not feasible; see Box 2 for more explanation of this.

Evaluating the use of the SSLP toolkit

The study included ethnographic observations of the public health teams in several LAs which had been sampled because they access to the SSLP toolkit. During the study it became apparent that it would not be possible to evaluated the toolkit as originally intended. While the purpose of the toolkit was to provide tools and approaches as an ‘entry’ into the licensing process, that PH practitioners could then build on and develop as they chose, it emerged that some practitioners were not using parts of the toolkit at all. This was due to:

- **High rates of staff turnover in some public health teams.** This meant that there had been loss of institutional knowledge between those who had originally been trained on the use of the toolkit (in 2013/14) and those who were currently conducting alcohol licensing work. This had resulted in a lack of awareness of resources the toolkit provides and how to use them among a few practitioners.

- **Problems with the data underpinning the toolkit’s data sheet resources.** From shortly before the start of the study there had been problems with updating the database (maintained by the GLA) that the toolkit data sheets were linked to, which were designed to provide recent postcode level data on alcohol-related incidents and crime. This meant that for the duration of the study the data sheets were not updated at all for some LAs. While a few PH practitioners still used older versions of the data sheets to identify rates of crimes and other incidents in the area local to specific premises, others stated that they could not use the data in representations as it was too out of date and they feared being challenged on it.

Due to these issues, it was decided that a formal evaluation of the SSLP toolkit was not feasible and it would not be appropriate to try to compare the influence on alcohol licensing decisions of PH practitioners with and without access to the toolkit.
Screening applications:

Among the PH practitioners in the eight LAs participating in the ethnographic observations, all practitioners undertook a process of screening the applications they received. A few practitioners indicated they were not sure if they always received all applications from the licensing department, occasionally noticing they had not received an application that had been sent to other responsible authorities. The process of screening undertaken by public health typically involved scanning the licence application and any accompanying documents, for possible health-related issues. They would look for any immediate concerns about the application, typically identified in relation to particular licensing priorities held by the public health team for their local area (for example, new off-licence applications or applications for late hours of sales).

In some LAs, these priorities were explicitly documented, for example as headed columns on a Microsoft Excel spreadsheet used to record information about each application. In several of the eight LAs observed this derived from the template provided as part of the alcohol licensing toolkit developed by SSLP. For other PH practitioners, including a few from LAs who had originally had access to the toolkit, these priorities were not explicitly recorded in a document, but emerged through discussion with the practitioner as they talked about the range of issues that they would typically look for in an application.

Key priorities:

Priorities varied between LA areas, but there were some common issues that many PH practitioners identified as indicators of an application requiring more detailed consideration and/or action from a public health perspective. These included:

- Late hours of alcohol sales (especially hours of sales that exceeded any recommendations for hours in the LA’s Statement of Licensing Policy)
- Early hours of alcohol sales (for example before 9am)
- Variations to extend hours of alcohol sales
- Premises within cumulative impact zones or special policy areas
- Premises that appeared to offer only ‘vertical drinking’
- Applications for new off-licence sales.

These priorities often seemed to reflect PH practitioners’ concerns about risks to health from the availability and accessibility of alcohol through licensed premises. There were also other, less clearly articulated priorities that seemed to shape the screening process. These included concerns over the
conditions proposed in, or missing from, the application (such as a lack of a condition mandating the checking of proof of age for people appearing under 25, or similar); a lack of clarity in the information provided; or concerns over the location of the premises even if not in a Cumulative Impact Zone (CIZ) or Special Policy Area (SPA) (eg if in a disadvantaged part of the borough, or another area of high density). If applications appeared to reflect one or more of these issues, they would typically be ‘flagged’ as requiring more consideration and possible action (described below).

Reasons for not undertaking screening:
All the eight LA public health teams included in the ethnographic observations were contributing regularly to the alcohol licensing process. However, when conducting focus groups with PH practitioners (14 participants across two groups), some participants from other LAs indicated that they did very little licensing work and did not typically screen all licence applications. One PH practitioner stated that due to a lack of capacity in the public health team, she did not receive licence applications regularly and would only take action on a licence application when requested directly by the licensing team, for example if they highlighted a possible health-related concern. Another PH practitioner stated that the other responsible authorities in her LA were very skilled and successful in taking action on licence applications, and so she would only act when requested as her input was not really needed.

“when a licence comes in that needs a public health perspective then they come to me. And we haven’t really been called up on because the police and the others have it so tight”

PH practitioner, focus group 02

Identifying when to take action:
Screening applications to highlight any immediate health-related concerns was typically only one part of the process of PH practitioners deciding whether to take action on an application, as was identified through the observations in eight LAs, and in the two focus groups with PH practitioners.
If initial concerns were identified, PH practitioners then took one or more different approaches to examining the issues in more detail to decide whether or not to take action. These included:

- Assessing the number of alcohol-related incidents (eg ambulance call-outs and injuries) and crimes (eg anti-social behaviour) reported in the area around the premises, using either the SSLP toolkit datasheets, tools or datasheets developed in-house, or other resources such as the SafeStats database (data on crime and other incidents in London provided by Greater London Authority (GLA)).
- Identifying whether the application corresponded with the recommendations of the Statement of Licensing Policy, for example its recommendations for hours of sale of alcohol or for the types of premises appropriate for certain areas such as residential areas.
- Locating the premises on a map to identify if its location was a concern, for example close to schools or alcohol treatment services, or in an area known for issues such as street drinking.
- Speaking with other responsible authority practitioners to ask if they had any concerns with the application and / or had any more information about the premises, the applicants or the local area.
- Discussing with other public health team members to decide whether the application was a priority.

Taking action on applications:

From the ethnographic observations in eight LAs, there were several different pathways identified through which PH practitioners would act on licence applications considered ‘problematic’ following screening. These were:

1) Representation followed by negotiation

Once an application had been screened and identified as potentially problematic, the PH practitioner would write a brief representation, stating their concerns about the application with justifications, and stating their recommended course of action (for example reject the application, or stipulate further conditions such as reduced hours of sale, or no off-sales). This would be submitted to the licensing department, and the PH practitioner would then see this a jumping-off point for possible negotiation with the applicant. The PH practitioner would wait for the applicant (or their representative) to contact them, and would begin negotiations at that point, if appropriate. If the negotiation was successful and the PH practitioner was happy with the revisions the applicant agreed to make to the application, they would notify the licensing team that they would withdraw the representation and detail what had been agreed. If the
negotiation was not successful, the applicant did not attempt negotiation, or the PH practitioner deemed it inappropriate (for example if recommending the revocation of a licence under review), the representation would carry forward and would be heard at the LA licensing sub-committee hearing. Here, the PH practitioner would present the representation, often bringing in more evidence to justify the recommendations. The verdict would then lie with the licensing sub-committee.

[PH practitioner] said that she saw this kind of representation as a starting point for negotiations and that most applicants don’t want to go to hearing. She said for them it can be risky going to sub-committee as the decision can go either way. She said they can be unpredictable; you can be sure that you’ve given a very good argument and they grant it anyway, and vice versa. She said the representation just “kicks it off”.

Excerpt from ethnographic fieldnotes in LA-02

2) Negotiation followed by representation

Elsewhere, PH practitioners described their approach as seeking to negotiate with applicants first, before submitting a full representation if necessary. They stated that they felt they were “more successful” through negotiation than through having representations heard at the licensing sub-committee, where they felt the committee’s verdict did not often fall in their favour. Following screening, and typically also following discussion of the application at the regular meeting of RAs in the council, the PH practitioner would attempt to negotiate on ‘problematic’ applications. They would attempt to contact the applicant or their representative to ask questions about particular details in the application and to ask them to revise the application or to include extra conditions on the licence, before the deadline for comments on the application. If the negotiation was successful, the PH practitioner would inform the licensing department that they did not wish to make a representation and had agreed certain conditions or changes with the applicant. If the negotiation was not successful, or if negotiation was not considered appropriate for the application, the PH practitioner would prepare and submit a full representation before the deadline, which would then be heard at the licensing sub-committee.
3) Different routes for low and high risk applications

In another LA, the PH practitioner described a process they had recently developed with the public health team to ‘streamline’ their responses to licence applications, due to concerns about workload. The PH practitioner had created a letter template that recommended key messages and several conditions they considered important for applicants to adhere to, including Challenge 25 age verification, publicising Drinkaware promotion materials, and a maximum strength for beers and ciders (see Box 3 below for descriptions of conditions used by PH practitioners). They stated that they use this for “minor reps” – applications considered lower risk to health - adjusting the wording where necessary and that the letter would be submitted to the applicants to open up negotiation around the application. Less commonly, for “major reps”, or higher risk applications, the PH practitioner would allocate the writing of a full representation to one of a small group of practitioners in the public health team, and they would prepare a representation with tailored wording and evidence to justify public health recommendations. For the “minor reps”, if negotiation was not successful, the PH practitioner would consider whether to submit a full representation, based on the capacity of the PH team and the extent of concerns about the application. The representations for the “major reps” would be heard at the licensing sub-committee.

She said if there is no “red flag” following screening they will send the minor rep letter, but if there is a “red flag” it will be allocated to a member of the team to prepare the full rep. She said they’ve had some successes with the minor rep letters; she said she’d sent letters for four applications that they wouldn’t otherwise have had time to respond too….

Excerpt from ethnographic fieldnotes in LA-05

In other LAs with public health teams active in the licensing process, the approach taken typically involved a representation for problematic applications with no expectation for negotiation, with representations often submitted to the licensing sub-committee just before the deadline for responses.
2.3 Making representations

Once PH practitioners had screened applications and decided to take action, there were several ways identified through the ethnographic observations in which practitioners would write representations to make recommendations to the licensing sub-committee.

**Recommending refusal or revocation:**

Attempting to negotiate with applicants (either before or after submitting a formal representation) was a common practice among many of the PH practitioners engaged in our research. However, on occasion, PH practitioners would make a representation that recommended full refusal of an application (either for a new licence or for a variation to an existing licence) or, in the case of a licence review, recommended revocation of an existing licence. These kinds of recommendations might be supported by claims of the inappropriateness of the type of premises seeking a licence (or variation) for the location in which it was situated. For example, in one LA engaged in the ethnographic observations, the SLP stated recommendations for the types of premises permitted and not permitted in certain parts of the borough. The PH practitioner would use this as a resource to support a recommendation to refuse, for example, a licence for a late-night bar in a residential area.

Variations to extend hours of existing licences, and to add off-sales to an on-sales licence were also the focus of many PH practitioners’ recommendations for refusal. For example, a PH practitioner described writing a representation to recommend refusal of an application to extend the hours of an existing premises licensed for off-sales. She cited the fact that the premises was in a cumulative impact zone and therefore extending the hours would add to the cumulative impact. For licence reviews, PH practitioners would sometimes use crime or ambulance data to demonstrate incidents in close proximity to the premises, and / or research data to support claims of the harms caused by a premises (for example, the effect of noise and disturbance on the well-being of local residents), to justify recommendations for the licence to be revoked.

**Recommending restrictions on the licence:**

Instead of a full refusal or revocation, PH practitioners might recommend modifications or restrictions to what is requested in a licence application. From the ethnographic observations we identified three key issues that were reflected in the restrictions or modifications requested in PH practitioners’ responses to licence applications:
- **Hours of sale:** PH practitioners would recommend a later start time for proposed sales considered ‘too early’ and / or an earlier finish time for sales considered ‘too late’.

- **Type of sales:** for applications requesting both on and off-sales, PH practitioners sometimes recommended not permitting off-sales (or vice-versa), particularly if they felt that having both was not integral to the type of premises or business model; for example, a pub requesting both on and off-sales.

- **Capacity of premises:** typically for on-sales applications, PH practitioners might recommend a restriction on the number of customers permitted in the premises to reduce harms such as noise and disturbance, for example from a late-night bar or nightclub.

These recommendations might be subject to negotiation between the PH practitioner and applicant, and / or they might lead to a full representation being heard at a licensing sub-committee if negotiation was not successful.

**Recommending licence conditions:**

What appeared more common during the ethnographic observations of PH practitioners’ licensing work was the recommendation of particular conditions on a licence, often the focus of negotiations prior to a licensing sub-committee hearing. These conditions were requested as a way of adding restrictions to a licence which much be adhered to, and typically related to shaping who alcohol is sold to, what products are sold and how, and features of the premises or mode of sales.

Recommendating conditions (in addition to mandatory conditions) was varied across the public health teams participating in the ethnographic research, with PH practitioners each having a few conditions that they would regularly recommend in a representation or in negotiations. The three most commonly used conditions were:

- Implementing a ‘Challenge 25’ rule: proof of age should be requested of any customer appearing to be under 25 years old, to prevent underage sales.

- Purchasing alcohol only with a table meal or with a take-away meal to restrict ‘vertical drinking’ in premises serving food.

- Setting a maximum alcohol by volume (ABV), for example 6% ABV, for beers and ciders, to reduce off-sales of high strength, lower cost products.

A couple of conditions requested by PH practitioners relate to alcohol industry-supported initiatives, including the Challenge 25 scheme to support age verification for alcohol sales (see [www.challenge25.org](http://www.challenge25.org)) and the Drinkaware campaign materials on reducing harm from drinking (see [Drinkaware](http://www.drinkaware.co.uk)).
https://www.drinkaware.co.uk/). While these initiatives were both designed to be voluntary for alcohol retailers to join in England, by being set as conditions on a licence, it becomes obligatory for the licence holder to uphold the initiatives to avoid breaching the terms of the licence.

A list of the full range of conditions requested by PH practitioners that were identified during the study is presented in Box 3 below. These were requested in addition to the list of mandatory conditions for a new licence or variation, and in addition to any other conditions requested by other RAs. For more information on mandatory conditions, see the Home Office guidance (2014), “Guidance on Mandatory Licensing Conditions”.

**Box 3** Description of conditions requested by public health practitioners during study

### Conditions requested by public health practitioners for licence applications, identified during the study

#### People-focused conditions

**Challenge 25**: proof of age must be requested before sales of alcohol to anyone appearing to be under the age of 25. While ‘Challenge 25’ was originally a scheme set up by the alcohol industry to support age verification policies for the sale of alcohol the phrase seems to have been adopted by some PH (and other RA) practitioners to denote a request for age verification, rather than explicitly aligning the condition with the Challenge 25 scheme.

**Dealing with drunkenness**: staff members must receive training on how to handle people who are drunk and refuse to sell them any more alcohol.

**Hotel guests**: alcohol can only be served between specified hours to verified residents of the hotel or their guests.

**Ticketed events**: sales of alcohol for on and/or off-site consumption are permitted only to people who have pre-booked tickets to an event, for example a festival.

#### Product-focused conditions

**Signing up to a local programme**: licence holder agrees to participate in a local alcohol-related programme or scheme, such as a ‘Reducing the Strength’ programme in which participants agree to remove high strength alcohol products (typically beer and cider) from sale in their premises.
Minimum unit price: alcohol cannot be sold for less than an agreed minimum price per unit (for example 50p / unit); typically a voluntary condition for off-sales.

Maximum ABV: no sales of beers and ciders that exceed the agreed maximum alcohol by volume measurement; typically used for off-sales, for example a maximum of 6% ABV for beers and ciders.

No promotional sales: alcohol not to be sold as part of any promotion, for example 'buy one get one free'; typically used for off-sales.

Sealed containers: alcohol to be drunk away from the premises must be taken away in sealed containers; typically used for premises with both on and off-licences, such as restaurants.

**Premises and serving-focused conditions**

Ancillary to food: alcohol can only be served with a table meal (for on-sales) or with a takeaway meal (for off-sales).

Delivery: delivery drivers must be over 18 and must request age-verifying identification of the customer receiving the order.

Drinkaware*: responsible drinking campaigns by Drinkaware must be publicised within the premises

No vertical drinking: restricting consumption of alcohol on premises to seated areas only.

Online sales: websites selling alcohol for delivery must promote responsible drinking on the website.

Positioning of alcohol: in off-sales premises, alcohol not to be positioned close to the shop entrance, for example not within 3 metres of the shop entrance.

Protecting for the future: conditions that stipulate that the premises must not be changed from the main activities and focus specific in the licence.

* Conditions with connections to industry-supported initiatives relating to alcohol sales and provision.

Recommending and negotiating conditions sometimes intersected with the work of other RAs, whereby PH practitioners might identify important conditions missing from an application but decide that it would be the focus of another RA. For example, a PH practitioner identified that a late-night bar/restaurant did not detail in their application a condition stating that they would keep a ‘refusals log’ (a record of people refused alcohol), but decided not to recommend this condition as they felt either the licensing practitioner or the police should recommend this.
It was not often clear how PH practitioners decided if a condition or issue with the licence application fell under the domain of another responsible authority, and this varied across different LAs. From across the different data collected, it appeared that many PH practitioners saw their scope as first, addressing issues relating to the availability and accessibility of alcohol, and second, minimising social and health-related harm to particular ‘vulnerable’ groups, for example people in disadvantaged areas, street drinkers and/or people with alcohol addiction, and children and young people. Yet, this scope was not always explicitly articulated and at times there appeared to be some overlap between the priorities of public health and those of other RAs, as observed during the ethnographic fieldwork. The interaction between public health and other RAs, and the influence of this on PH practitioners’ licensing work are discussed in more detail in section 3.2 of this report.

2.4 Information sources used to justify representations

Through the ethnographic observations and the survey we identified the different kinds of data, information and resources regularly used by PH practitioners to support their representations against licence applications and to justify any recommendations to the licensing sub-committee. These sources typically ranged from data and statistics on alcohol-related crime and incidents (such as ambulance call-outs), through data on local deprivation and other socio-economic characteristics of the local area and population, published academic research on alcohol harms, to local policies and programmes, and locally-commissioned research. There were also other, more unusual resources used on occasion, detailed below.

These sources reflect a range of different types of information, some more general, some relevant to the borough as a whole and some much more locally specific to a premises or location. Not all PH practitioners used or had easy access to all of these sources, and there were varying perceptions of the value and acceptability of these sources as ‘evidence’ to support representations (discussed more in section 3.4 below). Often, PH practitioners would use several of these types of sources in a representation, presenting both a broader picture of harms to health from alcohol and a more specific picture of the possible threats posed by a premises. Box 4 below lists the range of sources identified through the ethnographic observations and the survey, with examples of their use.
### Types of data, information and resources used to support public health representations

**The LA’s Statement of Licensing Policy.** For example, the recommended hours of sale of alcohol detailed in the SLP was often used in one LA to object to late hours of sales of alcohol requested in applications for new licences or variations.

**Other LA or public health strategies and policies,** not just focused on alcohol. For example, in one LA the focus on controlling the use of tobacco as a priority of the public health and wellbeing strategy was cited in a representation supporting a review of an off-licensed supermarket accused of selling illicit tobacco.

**Data on crime, anti-social behaviour and alcohol-related ambulance call-outs,** typically accessed through the SSLP toolkit data sheets, the SafeStats database, or an in-house data resource linked to crime and ambulance datasets. For example, the number of alcohol-related injuries between midnight and 2am within 100m of a premises was used in one LA to support a representation requesting a reduction in the hours of sale for a new bar.

**Data on local socio-economic characteristics.** For example, in one LA the PH practitioner said she frequently uses in-house data on deprivation quintiles by lower super output area to justify representations against off-sales licence applications and variations in deprived parts of the borough.

**Costs of treating alcohol-related health harms locally.** For example, the cost to the local authority of treating substance misuse in the borough, and of alcohol-related hospital admissions, was cited at the beginning of most representations by the PH practitioner in one LA.

**Locally commissioned research.** For example, a borough-wide survey of school children’s behaviours (including drinking and accessing alcohol) was used by one PH practitioner to justify a representation against a premises located close to a school and to support conditions to protect children from harm.

**Published research.** For example, one PH practitioner regularly cited research describing the association between early sales of alcohol and ‘problem drinking’ including street drinking to support representations against applications for early off-sales of alcohol, and to request later start times.

**Expert witnesses.** For example, in one LA the PH practitioner elicited a statement from the manager of an alcohol recovery service located close to a premises requesting an off-sales licence, to highlight concern about the premises for vulnerable people accessing the recovery service nearby.
Residents’ views. While there were no examples of residents’ views being incorporated into public health representations during the study, in the focus groups and other discussions many practitioners thought that using data from residents could be potentially very effective for influencing sub-committee decisions. One practitioner considered using residents’ reports of street drinking in future representations.

Maps of local areas indicating the location of relevant services and / or density of licensed premises. For example, in one LA, the PH practitioner used a map highlighting the locations of an alcohol treatment service and housing for vulnerable people, including those suffering from alcohol addiction, in close proximity to a shop requesting an off-sales licence to recommend rejection of the application, to protect vulnerable groups.

Data or information from Joint Strategic Needs Assessments. While there were no examples of this through observed directly during the study, in response to survey questions two PH practitioners indicated they would use data on the burden of alcohol and the availability of services from a JSNA to support representations.

In writing representations, PH practitioners tended to bring together several different types of data and evidence and often had a template for the representation that they would populate and modify according to the specific application. Several PH practitioners demonstrated how they would use higher-level, borough-wide information about alcohol related health harms at the beginning of the representation, before describing more specifically the issues identified with the application and premises, illustrated in the fieldnote excerpt below. For some practitioners, the template they used had been developed from resources as part of the SSLP guidance toolkit.

Next, [PH practitioner] talked me through how she writes reps for new applications. She said they have a template that she works from and opened up the document which had lots of headings and text written. She talked me through the sections; one described the health and wellbeing strategy, the next gave background and costs and the number of licensed premises. Then [PH practitioner] showed me the rest of the template which had lists of conditions under each objective, and she said she uses these to draw on, but also tries to add new conditions to the list, eg a condition around dealing with drunkenness.

*Excerpt from ethnographic fieldnote in LA-03*
2.5 What ‘success’ means for public health input into alcohol licensing

The survey captured PH practitioners’ perspectives on what are the priorities for public health input into the alcohol licensing process in their local authority. All 18 survey respondents stated that contributing to a local public health alcohol strategy and to broader alcohol licensing policy across the council were very or quite important priorities for public health licensing work. Similarly, 16 respondents felt that increasing understanding of public health values was very or quite important. Slightly fewer respondents (14 out of 18) considered that taking successful actions on licence applications (either negotiating conditions or having a representation upheld at licensing sub-committee) was very or quite important. The respondents who did not consider these actions to be important priorities represented public health teams that were active in alcohol licensing work (in negotiating conditions and / or making representations), as well as those who were not. This suggests that there is some local variation around what is perceived to be the main goal for public health in undertaking licensing work, and that taking actions on individual licences might be seen by some practitioners as valuable more for helping to contribute to broader strategic goals, than for shaping alcohol provision by individual premises. See Table 2 for a summary of what survey respondents viewed as priorities in their licensing work.

<table>
<thead>
<tr>
<th>Priority</th>
<th>Perceived importance</th>
<th>Very important</th>
<th>Quite important</th>
<th>Not very important</th>
<th>Not important at all</th>
<th>No response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negotiating conditions on an individual application before sub-committee</td>
<td></td>
<td>5</td>
<td>9</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Making a representation on an individual licence that is upheld</td>
<td></td>
<td>8</td>
<td>6</td>
<td>4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Increasing understanding of public health perspectives and values</td>
<td></td>
<td>14</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Working in partnership with other responsible authorities</td>
<td></td>
<td>16</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Contributing to and influencing local alcohol policies and strategies</td>
<td></td>
<td>16</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Influencing alcohol policy</td>
<td></td>
<td>16</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
In the ethnographic observations, focus groups and interviews, PH practitioners described a range of ways in which they considered the importance of undertaking alcohol licensing work, and what might count as ‘success’ from a public health perspective. As with the survey data, perceptions of what ‘success’ might look like did not always correspond with actions taken on individual licence applications, but referred to a broader role for public health in shaping alcohol – and other – policies in the local authority. These broader perceptions of success included:

- Ensuring public health are ‘part of the process’ and ‘doing their duty’ even if the desired outcome for a licence application is not achieved.
- Enhancing the strategic positioning of public health within local authorities.
- Diffusing public health values and perspectives into licensing and other areas of local authority work.
- Feeding into other, related strategies and areas of work eg Local Alcohol Action Areas (LAAA; a Home Office-led initiative to promote local partnerships across agencies and businesses to tackle alcohol-related harms; see Appendix A), tobacco control, healthy eating strategies.
- Balancing a ‘micro’ and ‘macro’ level approach to tackling alcohol-related harm.
- Successfully negotiating on a licence application before a hearing, to potentially save the council money and to avoid the ‘risk’ of an unfavourable decision at sub-committee.

[PH practitioner] also talked about other parts of her role, mostly with alcohol and procurement of services such as for IBA [identification and brief advice] and social marketing. She also said she’s coordinating the LAAA programme, and also the ‘CLeaR’ self-assessment tool from PHE. She said that there’s a bit of balance in her role and in public health more generally between the micro focus on licensing and premises, and the macro focus at the strategic level.

*Excerpt from ethnographic fieldnotes in LA-08*
2.6 Public health ‘impact’ in alcohol licensing

During the ethnographic observations and in focus groups and interviews, many PH practitioners talked about their impact on alcohol licensing decisions, often reflecting on it in fairly negative terms. The various reasons for their perceived lack of influence over the process will be explored in detail in the next section, but PH practitioners described sometimes or often feeling that they could not take action on an application (for example, due to a lack of public health licensing objective or lack of premises-specific data) or that their representation and recommendations would not be upheld by the licensing sub-committee. A few PH practitioners indicated that their licensing sub-committees did often appear to incorporate the public health perspective in their decisions, but that they did not always feel confident making representations without clear data or evidence to support what they were saying.

However, there were a number of examples, both directly observed in the ethnography or described in focus groups and interviews, of public health having direct impact on individual licence applications (presented in more detail in the next section). Furthermore, the analysis of nine months’ routine public health data on licence applications (including reviews) from five LAs indicated that there was impact on applications (modifications or refusals) in the vast majority of cases when PH practitioners did take action (see Tables 3 and 4).

Across these five LAs, analysis of the data recorded by public health indicated that PH practitioners took action on an average 18.6% of licence applications received (including reviews). This figure encompasses a wide range of activity, however; in one LA for no public health actions were recorded during the nine-month period, compared with two LAs for which actions were recorded for 30.3% and 33.1% of applications respectively.

This action was defined as negotiation with applicants and / or submission of a formal representation against an application or in support of a review. The information recorded in the five datasets was supplemented, where necessary, by information extracted from the LAs’ online licensing registers, to identify the outcomes of individual licence applications. The level of detail available in the datasets and licensing registers was not sufficient to identify whether specific changes to applications (such as modifications to the licence) and licensing sub-committee decisions (such as refusals or revocations) were the result (solely or in part) of public health actions. However, we were able to identify that for an average of 84% of the applications on which PH practitioners took action, there was some level of change to or impact on the applications. This impact was categorised as:

- the refusal of an application, or revocation of existing licence (in the case of reviews);
• an application for new licences or variations approved or an existing licence upheld but with additional conditions or restrictions imposed; and,
• successful negotiation by public health before licensing sub-committee hearing leading to changes in an application, and (where appropriate) subsequent withdrawal of the public health representation.

The number of applications on which actions were taken by PH practitioners across the five LAs are summarised in Table 3 below, and Table 4 summarises the outcomes of those public health actions. See Appendix C for additional data on the types of applications received across this period by the five LAs.
### Table 3
Summary of actions on licence applications extracted from data supplied by public health teams from five local authorities for the period January - September 2017

<table>
<thead>
<tr>
<th>Actions taken on applications</th>
<th>LA i</th>
<th>LA ii</th>
<th>LA iii</th>
<th>LA iv</th>
<th>LA v</th>
<th>Total</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Total applications received</td>
<td>128</td>
<td>68%</td>
<td>42</td>
<td>23%</td>
<td>188</td>
<td>30%</td>
<td>145</td>
</tr>
<tr>
<td>Applications on which action taken</td>
<td>0</td>
<td>0%</td>
<td>4</td>
<td>5.9%</td>
<td>10</td>
<td>23.8%</td>
<td>57</td>
</tr>
<tr>
<td>Of which, formal representation made</td>
<td>0</td>
<td>0%</td>
<td>4</td>
<td>5.9%</td>
<td>10</td>
<td>23.8%</td>
<td>57</td>
</tr>
<tr>
<td>No action taken</td>
<td>127</td>
<td>99.2%</td>
<td>64</td>
<td>94.1%</td>
<td>32</td>
<td>76.2%</td>
<td>129</td>
</tr>
<tr>
<td>Unclear if action taken</td>
<td>1</td>
<td>0.8%</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0.0%</td>
<td>2</td>
</tr>
</tbody>
</table>

1 Action taken includes negotiation with applicant and / or submission of representation.
Table 4 Summary of outcomes of licence applications on which public health action was taken, extracted from data supplied by public health teams from five local authorities between January and September 2017, and supplemented with data extracted from local authorities’ online licensing registers.

<table>
<thead>
<tr>
<th>Outcomes of applications on which PH action was taken</th>
<th>Individual local authorities</th>
<th>Combined</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>LA i</td>
<td>LA ii</td>
</tr>
<tr>
<td>Licence revoked / refused</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Variation refused</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Licence granted with restrictions</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Successful negotiation²</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>No success (licence granted / upheld)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Application withdrawn</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Unclear / unknown</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

²This includes successful negotiation on at least one, but not necessarily all PH recommendations.
3 Findings Part 2: Key influences on public health licensing practice and outcomes

This section presents a summary of the different factors shaping the extent to which PH practitioners engaged with the licensing process and their perceived success in doing so.

3.1 The status and influence of public health in licensing

*Perceptions of public health status:*

Although in some LAs PH practitioners were regularly taking action on licence applications, many PH practitioners who participated in the study perceived they were not always in a strong position to take action on alcohol licence applications or to influence the outcomes of licensing decisions. These perceptions appeared to relate partly to a lack of understanding of what the public health role is or should be within the licensing process in local authorities, and partly to the absence of a statutory health-oriented licensing objective. Some PH practitioners felt that the lack of health objective resulted in a less powerful status for public health within the licensing process, which they felt made it hard for them to act alone on alcohol licence applications without the support of other RAs. One PH practitioner indicated in an interview that she felt they had no capacity to act on any applications other than licence reviews, because of limited ability to justify representations except when there is existing evidence of harms resulting from a premises. In the ethnographic observations several PH practitioners...

She described two applications she’d received recently, both for supermarkets, and she’d been concerned about the early hours of sale of alcohol they’d requested. She said she called up . . .the police licensing officer to ask what he was planning to do, and he said that the police ‘couldn’t do anything’. . . She said she looked at the bullseye data, but there were no issues. She said that she had concerns with her “public health hat on” and tried really hard to find some justification but couldn’t link her concerns with any of the current licensing objectives, and concluded that her concerns were only health related. She said that when she’d spoken with the police, they’d suggested that she didn’t really have a ‘leg to stand on’.

*Excerpt from ethnographic fieldnotes in LA-04*
practitioners described frustrations of feeling unable to take action on some applications even if they felt there might be health-related risks.

A key perception emerged through different parts of the study of public health as a “poor relation” in the licensing process, compared with other, more established responsible authorities (RAs). In the focus groups, some PH practitioners described the challenges faced when making representations against licence applications, feeling that they cannot “go it alone” and their objections would only carry weight with the licensing sub-committee if concerns in PH representations are also made by other RAs. This was also reflected in the survey: a third (6) of PH respondents stated they would not make a representation if they knew no other RAs were making representations. In the focus groups, a few practitioners described being “left out of the loop” of the licensing process, for example not being invited to meetings with other RAs, or not being sent licence applications routinely.

When discussing the possible effect of a (hypothetical) public health licensing objective in the focus groups, many PH practitioners perceived that a health objective would raise the “profile” of public health in the licensing process, help others to understand the public health perspective, and facilitate public health making representations alone.

“It is hard to demonstrate what we do apart from just really core, basic activities. So I guess . . . [a health licensing objective] would help with some of that wider understanding of where [public health] is meant to sit across the local authority”

PH practitioner, focus group 01

Building status and influence:

In some LAs the status of public health within the licensing process has improved over time. One PH practitioner described in a focus group a process of developing “good working relationships” with other RAs over time, which enabled the public health team to feel they are now “genuine” partners in the process. The survey results also conveyed some positive perceptions of the position and influence of public health within the licensing process: 13 out of 18 respondents stated they were ‘quite influential’ (although the sample likely reflects public health teams that are more active in alcohol licensing work).
During the ethnographic observations in eight LAs, a few occasions arose where PH practitioners found themselves making the only representation against an application, usually because other RAs had withdrawn representations following negotiation with applicants. In most cases, the PH practitioners indicated that they would seek to negotiate and withdraw their representation as they felt it would be ‘risky’ to be the only ones presenting a representation at the licensing sub-committee, fearing they would not get the outcome they wanted. This sense of risk seemed to relate to both the time taken to prepare for a sub-committee hearing, and the possibility that the application would be granted without any restrictions; something that could potentially be mitigated by negotiating conditions or restrictions with the applicants directly. However, there were also a few occasions observed where the PH practitioners pursued their representations even without support from other RAs, and obtained favourable results either through negotiation, or through the decision made by the licensing sub-committee. Case Study 1 below presents an example of a successful outcome for public health who were left as the only responsible authority with a representation against an application.
In one local authority, public health submitted a representation against a new application for an off-sales licence for a branch of a chain supermarket in a deprived part of the borough with a known street drinking problem. The main focus of the public health representation was concern about early hours of sale of alcohol and about sales of cheap, high-strength alcohol by the supermarket. In the public health representation, they expressed concern about the early hours and recommended a condition that the supermarket sign up to the council’s ‘Reducing the Strength’ scheme operating in the area, and therefore agree to remove high strength beers and cider from the shelves.

Public health were then informed that the police, who had also submitted a representation with similar concerns, had negotiated with the supermarket applicants who agreed to work with the police to remove certain brands from the shelves. The police had therefore withdrawn their representation, leaving public health alone with their representation still standing. The public health practitioner was very concerned about this; she wasn’t convinced that the supermarket’s suggestion regarding the high strength products was sufficient without a condition for them to sign up to the ‘Reducing the Strength’ scheme. She was also frustrated that the police had withdrawn their representation, leaving public health, as she felt, “out to dry”. There were concerns about public health “going it alone” at the hearing, against the legal representative for the supermarket, and with the potential for the application to go to appeal at the magistrate’s court if the application was not granted. The practitioner said she wasn’t sure what to do, whether to pursue their representation or to withdraw it.

Eventually, the public health team decided to uphold their representation and a few days before the hearing, there was a series of negotiations between public health and the applicants, after which the supermarket agreed to the condition that they should sign up to the Reducing the Strength scheme and not sell cheap, high-strength alcohol in the new store. The public health team were very pleased with the outcome as the successful negotiation with the applicants meant that the application did not need to go before the licensing sub-committee.

**Case study 1: Example of successful negotiation by public health acting alone**
The views of other stakeholders on the status of public health:

In interviews and focus groups, some other licensing stakeholders (including practitioners from other responsible authorities such as licensing, trading standards, the police and others) stated that they did not see how public health could have much influence on individual licence decisions. This view appeared to relate to several issues: a lack of health licensing objective, the inability to relate population (health) data to individual premises, and the lack of an enforcement role for public health, unlike other responsible authorities.

“I don’t think [public health] have any powers. . . They have no more power than a resident in terms of saying these are the impacts that this activity could potentially cause”

Interview with licensing practitioner

Many stakeholders shared a similar view as PH practitioners that a health licensing objective (similar to that in Scotland) could give more power and status to public health as a responsible authority, and would help to increase awareness of health as an issue in relation to licensing. Yet some stakeholders suggested in focus groups and interviews that there might still be challenges in applying public health data to the licensing process, particularly given the expectation by many licensing sub-committees for evidence that is specific to the premises in question.

Other non-public health stakeholders (including other RA practitioners and a councillor) talked in interviews and focus groups about how public health are already able to bring value to the licensing process. They valued public health inputs in terms of supporting other RAs’ representations; helping to shape broader policies such as the Statement of Licensing Policy and cumulative impact policies; and developing broader awareness across LAs of the health harms from alcohol and the related costs. In a focus group with RA practitioners from one LA, practitioners (including licensing and trading standards officers) stated that they felt public health helped to give their own representations “additional strength”, for example by setting concerns about premises within a “wider society perspective”. A couple of non-public health stakeholders indicated in focus groups that public health are uniquely positioned compared with other RAs in that they can easily work across all four licensing objectives, and can also contribute to setting an “area wide agenda” for licensing across their areas. In interviews, a few other responsible authority practitioners described
when public health representations have been more effective, for example representations against applications for off-sales licences and reviews.

“every time an application comes in... that is asking for off sales [public health] seem to be very hot on the off sales aspect, they’re straight in there, why do you want off sales? If you don’t need it let’s take it off, you know they’re quite good in that respect”

Interview with police licensing officer

3.2 Relationships with other Responsible Authorities

A key factor that appeared to shape public health practitioners’ levels of engagement and influence in licensing was the relationship between public health and other RAs in their LA. This emerged across all parts of the study, with some PH practitioners reporting little or no regular contact with RAs and others having much more regular engagement. In the survey, almost all respondents (17 out of 18) stated that they considered working with other RAs to be ‘important’ for licensing work. However, only 8 stated they regularly attend RA meetings, and 10 indicated they do not have or do not regularly attend RA meetings. All eight respondents who attend RA meetings regularly stated that they felt they were ‘quite influential’ in the licensing process, in contrast with only half (5) of those who do not have regular engagement with RAs.

Ways of engaging with other responsible authorities:

There were a range of ways identified through the study (observed through the ethnography and described in the focus groups and interviews) in which engagement between public health and other RAs occurred. In some LAs, this took the form of regular (eg three-weekly, monthly or quarterly) meetings between all RAs to discuss licensing applications in process, and in some cases, existing licensed premises that were considered ‘problematic’. In other places, public health engagement with other RAs was less structured, for example meeting every few weeks with a licensing officer to discuss current applications, or more ad hoc contact, for example calling up a police licensing officer to discuss issues and plans of action for particular licence applications. In a few LAs included in the ethnographic study, there were other organisational structures in place to promote engagement between public health and other responsible authorities, for example the co-funding of a post by
public health and trading standards, to facilitate working across the two departments (for licensing and other issues).

**The value of engagement with responsible authorities:**

Overall, PH practitioners understood the value of being able to engage regularly with other RAs, suggesting that meetings or ad hoc contact enabled them to gain additional perspectives on premises from enforcement officers with more ‘on-the-ground’ knowledge, and to help position their actions and representations in relation to others.

They moved on to looking at outstanding applications. Regarding [off-licence premises], [PH practitioner 1] said she’d emailed [licensing officer] for an update and in the RA meeting on Wednesday, it seemed everyone was going in on it. [PH practitioner 1] said that the police want the hours pushed right back. [PH practitioner 2] said they’d make the decision that they object to the license, but if it is granted, they want the hours reduced.

*Excerpt from ethnographic fieldnotes in LA-01*

**Lack of engagement with responsible authorities:**

Through the ethnographic research we also observed PH practice in a few LAs where there were no regular RA meetings. In these situations, PH practitioners described frustrations with and limitations of not having good connections with other RAs, reflecting that it is “really difficult doing this in isolation”. In one LA, the only regular contact the PH practitioner had with other RAs was via a police licensing officer whom she would call up to discuss applications that she found more challenging. This PH practitioner felt that regular meetings with all RAs would be more beneficial for her licensing work.

[PH practitioner] said she also wishes that she could meet up more with the other RAs to discuss all the applications and premises, and to look for opportunities to “join up a bit”. She said that licensing are helpful but tend to be “hands off” unless she approaches them, and they never put reps in. She said that the police are more proactive however.

*Excerpt from ethnographic fieldnotes in LA-04*
In another LA included in the ethnographic observations, there had previously been regular RA meetings but these had (temporarily) stopped for a reason not clearly understood by the public health practitioners. One PH practitioner here indicated how difficult she found the licensing work without these connections to help understand applications, and took efforts to try to engage more closely with other RAs over a period of several months. The development of the relationship between public health and other RAs in this LA are described in more detail in the example in Case study 2 below.

**Case study 2: Example of developing relationships between public health and RAs over time**

In one local authority the public health team described sometimes feeling frustrated with their attempts to contribute to the alcohol licensing process, which were not as successful as they hoped in terms of process or outcome. One reason they identified for this was the lack of regular engagement between public health and other responsible authorities, meaning the PH practitioners sometimes felt they were not working in partnership with other RAs, and that their representations did not always support each other.

Keen to strengthen their inputs to the licensing process, the public health team put in place several strategies to try to increase engagement with other RAs and make their working relationships more effective for licensing outcomes. These strategies included:

- Contributing to the Statement of Licensing Policy to embed the ‘health in all policies’ perspective into the local authority licensing framework;
- Setting up a meeting with other RAs to discuss existing public health priorities and criteria for licensing, and sharing public health data on local alcohol harms to establish shared goals and targets;
- Arranging for a PH practitioner to sit with the licensing team once a week to build good working relationships and facilitate information sharing.

The public health team have seen an increase in collaboration between RAs as a result, and feel they are contributing more effectively to the licensing process. A PH practitioner identified several successful public health representations against licence applications which she felt were strengthened when the “RAs come together”. The outcomes of these representations included restrictions of hours for two pub chains requesting 24 hour licences, and the withdrawal of an application by a low-cost retailer to start selling alcohol in their high street store.
Views of other stakeholders on engagement within LAs:

Among other RAs and licensing stakeholders participating in the focus groups and interviews, some indicated that there was a lack of capacity in their LAs to hold regular meetings to discuss licence applications, due to budget cuts and understaffing. A couple of non-public health practitioners from different LAs implied in interviews that public health were not necessarily ‘missed’ by other RAs if there were no mechanisms for engagement between them. This was explained as public health having never really been part of the licensing process historically, or because of the lack of health licensing objective which, they felt, restricted the contributions public health can make. However, many other non-public health RAs and licensing stakeholders from other areas described the value of RAs – including public health – working closely together, through regular meetings, colocation of practitioners within the council building, and / or on particular projects such as updating the Statement of Licensing Policy.

“One of the great things about [the updated SLP] is that a lot of work was put into developing it and a lot of consultation with the other responsible authorities. . . we all felt that not only were we engaged with it but . . . we were fully referenced with it, we could fully buy into it.”

Interview with trading standards officer

In addition, a couple of non-public health licensing stakeholders indicated in interviews that they thought public health could take a greater role in coordinating and even leading the engagement among RAs in their LAs. In an interview, one stakeholder, a senior enforcement services manager, suggested that public health’s enthusiasm to be involved might help inspire others who have “settled into a routine” with the licensing process, including those departments with an official RA role but who rarely contribute, for example Children’s Services. Another stakeholder from a legal background indicated that public health could take a leading role in bringing all RAs together and should be “sitting at the head of the table” to guide meetings and help shape action on licensing across the whole town, borough or area.
3.3 Perceptions of licensing sub-committee and decision making

Another important factor shaping PH practitioners’ motivations towards licensing work and perceptions of their level of influence was their views on the licensing sub-committee in their local authority and understanding how decisions about licence applications are made.

**Competing priorities:**

In general, there was a lot of frustration expressed by PH practitioners, perceiving that members of their licensing sub-committee ‘don’t understand’ the public health perspective. In focus groups and during the ethnographic observations, many PH practitioners discussed examples of being surprised by a committee’s decision on an application they viewed to be have obvious concerns. Several PH practitioners recounted having their representations criticised or ‘picked apart’ in licensing sub-committee hearings, either by the applicant’s representative or by members of the sub-committee, for example for the lack of specificity of the evidence presented in relation to the premises. This fear of being challenged and of failure among some PH practitioners appeared to dissuade some from submitting representations.

Many PH practitioners clearly recognised that there were often competing interests at play in the decision making process at licensing sub-committees. This meant that PH practitioners did not always agree with – or sometimes did not understand – the decisions made on individual licence applications. PH practitioners talked during the ethnographic observations about the variety of perspectives among members of the sub-committees. Some elected members were considered to understand and be sympathetic towards health issues, but others might be much more interested in promoting the local economy, and were therefore perceived to ignore concerns articulated by public health. For example, while waiting to go into a licensing hearing in one LA during ethnographic fieldwork, a PH practitioner and environmental health practitioner discussed the committee members for that hearing in terms of their likelihood to uphold the representations made by RAs.

Looking at the agenda documents, [PH practitioner] and the environmental health practitioner started discussing the councillors listed, profiling them in terms of being “pro-business” and likely to accept anything. They seemed particularly concerned by the man who would be chairing the meeting in the absence of the usual woman, as they both seemed to think he would be very lenient, and supportive of businesses.

*Excerpt from ethnographic fieldnotes in LA-02*
Some PH practitioners also talked about the broader economic strategy and policies across their local authorities (and beyond) which they thought influenced the extent to which public health concerns would be taken into consideration by the licensing sub-committee. This reflected a strong perception that public health concerns regarding the availability and accessibility of alcohol would often be considered in tension with strategies to promote the local economy:

“A new challenge for us with . . . nights, the GLA’s Night Czar contacted all of the committee and all the authorities . . . making the case for a very late licence, late licensing hours and . . . that throws a new thing into the mix with making a public health case”

PH practitioner, focus group 02

Committees are risk-averse:

PH practitioners from different areas participating in the focus groups and ethnographic observations also perceived that their licensing sub-committees were ‘risk averse’, not wanting a licence application decision to be taken to appeal at the magistrates’ court for appeal. It was understood that this would be a costly process for the LA and might be harmful from the perspective of the reputation of the LA and setting a precedent for future licence applications. PH practitioners perceived that some public health representations, and the evidence used to support their recommendations, might be considered ‘risky’ by sub-committee members as they may not be ‘sufficiently robust’ in an appeal, due to the lack of a health licensing objective and evidence not being premises-specific. This might leave it open to challenge by the legal representation of applicants.

[PH practitioner] said she could only think of one time the committee has rejected a licence, and they’re much more likely to give conditions than reject an application . . . she said “what I aim for is conditions”.

Excerpt from ethnographic fieldnotes in LA-05
Support for public health perspective:

There were examples from several LAs where licensing sub-committees were perceived to understand the public health perspective, and where it was felt public health representations and evidence were considered appropriately by committee members. In one LA participating in the ethnographic observations, the PH practitioner articulated frustration with not being able to take more actions on licence applications because of a lack of health objective. However, she also said that she thinks the committee are generally supportive of public health and other RAs’ representations. She said she’s always “done very well” when her representations have been heard at sub-committee, and that she has never “come away with nothing” as result of a hearing. In another LA participating in the ethnographic observations, the PH practitioner described in positive terms the relationship between public health and councillors, stating that the licensing sub-committee members encouraged the use of particular kinds of public health data in representations, such as data on alcohol and domestic violence. This PH practitioner also indicated that the sub-committee members typically explain their decisions carefully to the applicants, with reference to public health data as appropriate.

Picking battles:

From the focus groups, interviews and ethnographic observations, there appeared general agreement across all PH practitioners actively engaged in licensing work that it was important to ‘pick their battles’ carefully, balancing the anticipated risks and benefits of taking action on an application, and compromising where necessary.

The possible risks of taking action on an application included the possibility of it not having influence at the sub-committee, meaning the time taken to prepare a full representation was wasted. Other perceived risks included negatively affecting relationships and position with both the sub-committee and other RAs, if public health representations were considered to be unnecessary, over-the-top or a waste of time if not clearly justified. Finally, some PH practitioners talked about the trade-off between submitting a representation recommending refusal of an application that is ignored by the sub-committee, and negotiating on conditions with the applicant without submitting a representation, so that they can have some kind of positive outcome, even if it is not the ideal one.
Views of other stakeholders on public health presenting at licensing sub-committee:

Other licensing stakeholders and RAs also commented on the challenges that PH practitioners might face in the licensing sub-committee hearing, in focus groups and interviews. Some acknowledged that the legal representatives of applicants can create an intimidating atmosphere in the hearing context, and that PH practitioners may not have much experience in dealing with this and challenges to their evidence. A few of these stakeholders also suggested that applications from larger businesses, with more money to spend on legal representation, can be particularly challenging for PH practitioners unused to defending their position against legal professionals. A couple of other, non-public health RAs talked in interviews about facing similar difficulties to public health in sub-committee hearings, in terms of having their representations and evidence aggressively challenged by applicants’ legal representatives, and also being discouraged by committee members from taking too many applications to the committee. A police licensing officer said that they now “pick and choose” which applications they take action on and only go for “battles... that are worthy of fighting”, preferring to negotiate as much as they can.

However, there were also perspectives shared in focus groups and interviews with non-public health stakeholders that licensing sub-committee members seek to balance the interests of both the RAs and the applicants. Rather than reflecting political positions, some thought that sub-committee members’ decisions reflect their interpretation of the Licensing Act and their LA’s Statement of Licensing Policy. A councillor and member of the licensing sub-committee in one LA stated in an interview that they (the sub-committee members) always take each application on merit, and are always guided by the details of their SLP, including cumulative impact policies. The councillor described the contribution to licensing of public health in her LA, stating that they do not often make representations that are heard at a hearing, but that when they do, they are likely to be influential on the committee’s decision.

Excerpt from ethnographic fieldnotes in LA-02

[PH practitioner] said she’d conciliated eventually on this [application]; they’d agreed on an earlier closing time and had negotiated back and forth by email on a later start time. She said she’d got a call from licensing saying they were the only ones “left in” with a rep, so she realised it wasn’t worth going to hearing and agreed on a 9am start time. She said she was ok with that as she thought it wasn’t a “typical off-license”.

Excerpt from ethnographic fieldnotes in LA-02
3.4 The value of public health evidence

Expectations about the type of data and evidence that should be used to justify representations against alcohol licence applications were important in shaping how PH practitioners approach licensing work and their perceived ability to influence decision making.

*Population versus premises-specific perspective:*

Many PH practitioners indicated during ethnographic observations and in focus groups that they felt limited by the types of data they have available to them and the expectation that they should show how an individual premise is likely to lead to alcohol-related health harms. This reflected the perceived tension between the ‘population perspective’ typical of public health work, and the ‘premises-specific’ perspective assumed within licensing legislation. Some PH practitioners indicated concern that they are not able to ‘prove’ that health and other harms recorded at a local area level can be attributed to a single existing premises, or that the granting of a new licence will directly influence these population harms. As a result, some PH practitioners felt their contributions to alcohol licensing processes could be critiqued or undermined if they tried to use this data in a representation, especially without the support of other RAs’ representations.

“you don’t have any evidence . . . the data I have around assaults and so forth, none of that is premises related, that bit isn’t recorded in A&E so you can’t tie it to anything. So it would be very generic and like you say, you would just get ripped apart if you were on your own pushing for something like that”

PH practitioner, focus group 01
Defining the nature of ‘evidence’ in the licensing process:

A few PH practitioners discussed during ethnographic observations and in interviews different understanding of what counts as ‘evidence’ in relation to alcohol licensing. One PH practitioner described a discussion with the legal adviser at her LA regarding the expected structure and format of representations, including what can and cannot be used as evidence to justify recommendations. She said she was told that published (academic) research did not count as ‘evidence’ in a representation as it was not ‘fact’. It was also acknowledged in a focus group with a range of non-public health stakeholders that there are different interpretations of the Licensing Act in terms of whether or not representations must be premises-specific, and the degree of geographic specificity required or accepted in the decision-making process.

Across the whole study, different levels of geographical specificity of evidence were perceived to be acceptable (or not acceptable) in different LAs. This was reflected in how some PH practitioners used the SSLP toolkit data sheets. In one LA, the PH practitioners regularly presented data on the ranking of the ward in which a premises was located for alcohol related incidents and crime, whereas in other LAs PH practitioners felt only data from the ‘bullseye’ sheet on numbers of incidents down to 100m around the premises postcode were acceptable in a representation. In one LA, the PH practitioners felt uncomfortable with the lack of updates to the sheets, and chose to access the SafeStats database directly, enabling them to access data to within 50m of the premises postcode, which they felt presented as stronger picture in representations.

However, despite concerns about the (lack of) specificity of most public health data, a wide range of different types of data and information were reported or observed as used in public health representations (see Section 2.4). Many public health and other RA practitioners recognised the value of a broader, population-level perspective in the licensing process, articulated in focus groups and interviews. There was a sense that PH practitioners can offer something of a “unique” perspective in the licensing process, with access to different kinds of data and also, often, strong skills in data analysis and interpretation, enabling them, for example to make comparisons between wards within a borough. Some PH practitioners recounted examples in focus groups of how the evidence presented in their representations had been well-regarded by the licensing sub-committee, enabling them to “see the numbers in a wider health and wellbeing context”. In another focus group, other RA practitioners commented on the value of public health data and evidence in terms of its ability to describe pre-existing problems in an area and to convey the full range and impact of alcohol-related harms, which was considered very useful for supporting recommendations made by other RAs.
In interviews and focus groups, other non-public health stakeholders described a more incremental process through which public health might be able to use population-level data and evidence to shape the wider licensing process. One licensing stakeholder from a public health team outside London recommended a process undertaken in his local area starting with LA licensing policies, using area-level data on harms to try to shape cumulative impact policies and the SLP, which would, in turn, enable more public health input on individual licence applications once the policies are in place.

“We started off by looking at cumulative impact policies and zones before getting our teeth into specific cases, because by doing that we can set the evidence as the context in which the premises in those areas trade.”

Licensing stakeholder, focus group 04

In the same focus group, another stakeholder suggested that it is “early days” for public health’s licensing role, and while they build up their skills and experience, they can be useful in passing data to other RAs that could be used in their representations.

Communicating evidence:

A key message that emerged from the other, non-public health RAs and licensing stakeholders through focus groups and interviews was the need for PH practitioners to improve the presentation and communication of their data and evidence in representations. While a few suggested that PH practitioners in their LAs had worked well to tailor their evidence to the format and style expected within the licensing process, others stated that PH practitioners can ‘overwhelm’ decision makers with too much data and evidence.
There was also an indication that the style of language used by PH practitioners in their representations may not be suitable for the more ‘lay’ perspective of licensing sub-committee members, and that they should seek to improve both written and verbal communication of key information to a non-specialist audience. Through the ethnographic observations, some PH practitioners described ways of communicating their evidence that they thought was more effective and convincing to the licensing sub-committee. In particular, a few PH practitioners using the SSLP toolkit stated than using visual representations of data such as a ‘bullseye’ image copied from the SSLP data sheet was valuable for illustrating the number of incidents within 100m, 200m ... up to 500m of the premises’ postcode. Others talked about using maps, such as those highlighting different levels of deprivation across wards within the borough, to emphasise the disproportionate levels of harms faced in disadvantaged areas.

There were also more unusual examples of when public health evidence had been considered valuable and influential that did not relate to the presentation of data in a representation, for example, during ethnographic observation of a hearing for a review of a licence in one local authority. At the hearing the PH practitioner was asked by a member of the sub-committee to comment specifically on evidence around sleep disturbance and impact on children’s educational attainment and well-being, following reports of excessive noise from the premises disturbing the sleep of families nearby. The PH practitioner’s response – briefly stating that there is strong evidence of the negative impact of sleep disturbance on children – was considered to be well-regarded by the committee and influential in their decision to revoke the licence of the premises. This seemed to be an example of public health influencing the licensing process by nature of their expert status and knowledge of broader evidence, rather than the presentation of specific data on a premises.

“I’ve certainly seen things where you know roughly what somebody’s trying to say but by the time you’ve gone through 14 spreadsheets and 16 maps without any, you know, point and that means you’ve, you’ve lost it a bit and I think that’s been an obstacle.”
Sharing best practice:

Finally, the study identified that PH practitioners know that it is important to learn from their peers how other practitioners are using evidence to make representations and impose conditions. During the focus group discussions, PH practitioners were interested in hearing what kinds of research and data others had drawn on in representations and to justify particular conditions, such as no early sales of alcohol. They also talked about the importance of sharing ‘best practice’ across the public health profession and wanting to learn from each other, which conveyed a perception that non-locally specific knowledge and evidence was still considered important and valuable for PH practitioners trying to write effective representations. Indeed, at the end of the first two focus groups, practitioners remarked how useful it had been to hear and learn from others’ experiences and they wanted to keep in touch to continue to share learning.

3.5 The strength of local policies and programmes relating to alcohol

Another influential factor on PH practitioners’ licensing work was the presence and strength of broader policies and programmes relating to licensing and alcohol.

Statement of Licensing Policy:

While all LAs have a statutory duty to have a Statement of Licensing Policy, it was not always used and referred to as a resource by PH practitioners in their representations. In the survey, only half of respondents stated they would use their SLP when writing a representation. In one LA where
ethnographic research was conducted, the SLP was considered by the public health team to be ‘very strong’ in terms of the amount of detail in the policy regarding recommended hours of sale of alcohol, and the kinds of licensed premises appropriate in different areas in the borough. The PH practitioner would regularly cite recommendations of the SLP in her representations, as a justification for requesting reduced hours of sale of alcohol by a premises, or for recommending the refusal of an application for a premises unsuited for a residential area, for example. This example is described further in Case Study 3.
Case study 3: Example of public health using and influencing the Statement of Licensing Policy

The public health practitioner from one LA stated that there was a ‘strong’ Statement of Licensing Policy that she found supportive for her licensing work. The SLP had clear recommendations for the closing hours and hours of last sales of alcohol; detailed three cumulative impact areas with different licensing goals, and also made recommendations for the kinds of premises that are and are not appropriate in different parts of the borough. The PH practitioner would routinely cite the recommendations of the SLP in representations, using it to justify requests to reduce hours of sale or to recommend the refusal of a licence for an unsuitable premises, such as a nightclub in a residential area. On several occasions the practitioner suggested that applications for licences that clearly fell outside the SLP’s recommendations were “really easy to argue”.

However, the PH practitioner stated that it was frustrating that there were no recommendations for the opening hours and sales of alcohol in the morning stated in the SLP, something she felt was important in some contexts, to help prevent ‘problem drinkers’ accessing alcohol early in the morning, and reduce related issues. The practitioner often focused explicitly on early hours of sale when making a representation, citing evidence of an association between early hours sales and street drinking to support her objections. She said that other responsible authority practitioners had become so used to her focusing on early sales that they now started to pick up on the issue in meetings or in their own representations. This has led to acknowledgement across different RAs that the revision of the SLP in three years’ time should include inputs from public health to make recommendations for opening hours and start of sales of alcohol explicit in the SLP.

This initial groundwork has led to a number of opportunities for public health to add value to the licensing process in their LA. Leveraging their analytical capability, the public health team are in the processing of pulling together a number of different relevant datasets to build a holistic picture of alcohol-related harm across the borough. It is hoped this tool will help public health and the other RAs better substantiate licensing decision and further influence the SLP for their LA.

There were several examples during the ethnographic research of PH practitioners justifying representations by referring to LA priorities detailed in the SLP. An example of this was in a
representation against an application for a late night bar, where the PH practitioner quoted directly from the section of the SLP which stated the importance of ‘limiting nuisance from late night disturbance’. Elsewhere, the SLP was referred to less regularly, and sometimes used to explain why action would not be taken on a licence application, particularly if the hours requested for a premises fell within the recommendations of the SLP. A few PH practitioners indicated they had never really thought to use their SLP as a justification for a representation, especially if they considered it to not be particularly specific in its recommendations.

_Cumulative impact policies:_

Another key policy that influenced PH practitioners’ licensing work was cumulative impact policy (CIP). A CIP designates specific areas with high density of alcohol outlets as ‘cumulative impact zones’ or ‘special policy areas’, wherein applications for new licences or variations for premises within these areas have to demonstrate that they would not add to the cumulative impacts of alcohol in these areas. Most LAs represented in the research had a least one CIZ in their borough, and if a licence application fell within one of these areas, PH practitioners perceived they had more power to make a representation against it.

_PH1:_ I think it’s about public health being taken seriously, and I think . . . if [a premises] is in the cumulative impact zone, that helps us.

_PH2:_ Yeah, definitely, definitely.

_PH3:_ Oh that’s easier, that’s easier yeah.

PH practitioners, focus group 01

A public health lead from one LA with only a limited amount of public health alcohol licensing work indicated in an interview that her time was far better “invested” in contributing to the development of policies such as CIPs, and she felt that influencing the CIP was where they had had most public health impact in relation to licensing. This was echoed by a range of other RAs and licensing stakeholders, who indicated in focus groups and interviews that they thought public health could have more influence on the alcohol environment through contributing to policies such as the SLP and CIP. In one LA without a CIP, RA practitioners reflected during ethnographic observations on the challenges they faced with the changing local economy, and how the saturation policies in other,
neighbouring boroughs were increasing the density of premises in their area. They implied this would be easier to manage if they had their own CIP.

However, PH practitioners did acknowledge some of the limitations of CIPs, for example if there were exemptions for certain types of premises (such as theatres or restaurants) or opening hours. For example, in one LA participating in the ethnographic observations the PH practitioner stated that the CIP had been recently revised so it only applied to premises within the designated area that were requesting hours after 23.00. A few PH other practitioners discussed in focus groups that the presence of a CIZ did not necessarily mean the licensing sub-committee would reject a new application for a premises located within it. In some areas there was also sense that the boundaries of existing CIZs did not reflect the changing nature of local areas and the density of premises within them.

Other alcohol programmes:

There are a few examples that emerged across the study, particularly through the ethnographic observations, of other LA alcohol programmes or initiatives which intersected with licensing work. For example, the case example in section 3.1 describes how the PH practitioner successfully negotiated with the applicant to add a condition to the licence that they would sign up to the council’s *Reducing the Strength* (RtS) programme and not sell high strength beers and ciders in the shop. See Appendix A for a glossary describing RtS and other local policies and programmes. In another LA, the PH practitioner and a licensing officer both talked during ethnographic observations about the local RtS programme as way to reduce alcohol-related harms from off-licences, with attempts to enforce the conditions on licences relating to membership of the scheme. As such, the RtS programme was considered to be another mechanism for shaping the availability of alcohol locally, and also a resource for PH practitioners to draw on when negotiating with licence applicants, to justify their concerns and recommend conditions on the licence. Furthermore, it appeared to be another mechanism for different RAs, including public health, to work together and build relationships.

3.6 Resourcing and organisational context

The capacity of public health practitioners was, unsurprisingly, an important factor shaping their contributions to licensing work.

Lack of capacity:
Many PH practitioners talked in focus groups and during ethnographic observations about the amount of work taken to write a full representation. PH practitioners who were doing little or no licensing work indicated in focus groups that they feared having no influence at all over licensing decisions and therefore it was very difficult to justify spending time on making representations. Many PH practitioners described have multiple different areas of work to cover, and even with a focus on alcohol, licensing might not be considered a priority if staffing and resources are restricted.

“I’ve got the remit of the drug and alcohol programme . . . So I do everything, so I commission the service, I monitor it, the treatment system, [and] I’m supposed to do anything around licensing, so clearly I can’t do that much really . . . it’s just not going to happen”

Public health practitioner, focus group 01

There were examples of where PH practitioners had tried to find ways to reduce the burden of writing representations, such as the approach taken in one LA (described in Section 2.2) where they had developed a letter requesting particular conditions for ‘low risk’ applications, and only wrote full representations for ‘high risk’ applications. Other PH practitioners talked of building up an ‘evidence base’ over time of different resources that they could draw on quickly when making representations, to reduce the amount of time needed to look for evidence to justify concerns.

A few practitioners described having developed in their role such that they were now much quicker at screening applications, deciding which require action, and then drawing on templates and previous representations to create a new representation tailored to a specific application. Some of the templates used by PH practitioners, as observed through the ethnographic fieldwork, appeared to be derived from the resources provided as part of the SSLP toolkit. These included a template Excel spreadsheet for recording information and actions taken on licence applications, and a template for writing representations.

She showed me her folder for ‘research’ on her computer, and said she’s been gathering more research from Scotland, for example from the policy around off-licences only being allowed to open from 10 to 10. She said she hopes some of this research . . . might be able to feed into the revision of the SLP, so that they can strengthen it, for example around opening hours.

Excerpt from ethnographic fieldnotes in LA-06
**Context of budget constraints:**

The challenges faced by public health teams in terms of staffing and resources are, of course, reflective of the broader local government context, with widespread budget cuts and restructuring. There was a sense, occasionally articulated explicitly by public health and other practitioners, that taking too many licence applications to hearing by putting in representations could be costly to the council as a whole. There was also the fear of applications going to appeal, which would be extra expense for the council. Additionally, the challenges of staffing and time were evident across other RA departments, illustrated in an interview with a police licensing officer who described his team’s own challenges in making licensing work a priority in the face of staff shortages and increased workload. He also said that the frequent restructuring of police teams across areas in London might impact negatively on local relationships established within local authorities, making processes such as regular RA meetings a “casualty” of the changes.

**Challenges retaining knowledge:**

In a few LAs involved in the study there was an indication of fairly frequent turnover of staff in the public health team, which sometimes affected the alcohol licensing role due to the lack of handover of knowledge to the new person taking over the work. In one LA participating in the ethnographic observations and which had received the SSLP toolkit, neither the PH practitioner nor her line manager appeared to have much knowledge of the existence of the toolkit or how to use its resources for the licensing process, because they were both fairly new in the team. This meant they had tried to work out for themselves the best way to carry out the alcohol licensing work, without much guidance from the previous practitioner. Similarly, in another LA participating in the ethnographic observations, the PH practitioner explained that it is usually a public health registrar (trainee) who is allocated to the alcohol licensing work, but that this can be problematic as they are only ever in post for one year and there can be little opportunity for handover between people. This suggests that without more continuity and better processes for sharing knowledge and practices, the important skills, understanding and relationships built up by PH practitioners as they develop within the licensing role may be lost or undermined with frequent turnover of staff.
4 Conclusions and Recommendations

4.1 Summary of key findings

This study explored the practices and perceptions of public health contributions to alcohol licensing work across local authorities in Greater London. The key findings from this study are summarised below:

Position and status of public health in licensing:

- There is great variety in terms of the amount of licensing work undertaken by public health practitioners in different London LAs, the approaches taken, and their (perceived) influence on alcohol licensing decision making.
- Many PH practitioners feel they are limited in their contributions by a lack of status for public health within the established licensing process, and by the tension between the population perspective they can offer and expectations for premises-specific data when making representations. However, some PH practitioners feel they are developing more skills and confidence in submitting representations and negotiating with licence applicants.
- Some PH practitioners feel they cannot act alone, without the support of other responsible authorities, as their representations would not be influential and / or their evidence would be critiqued in a licensing sub-committee hearing. However,
- Many PH practitioners feel that a fifth, health specific licensing objective would help them to have more status within the licensing process. However, some PH and non-public health practitioners think a fifth objective would not overcome the challenges of how to present area or population-level data within the licensing process, and that there are existing techniques that can be applied to increase public health input and influence.

Having an influence on licensing:

- There are examples of public health successfully acting both with, and independently of other RAs, and PH practitioners in some areas seem to have regular influence over licence applications, most commonly through negotiating with applicants (for example on hours and / or on adding conditions to a licence) before a hearing.
There are many different types of data, information and resources that PH practitioners use to justify their recommendations and representations, but the value of these from the perspective of other RAs or the licensing sub-committee can vary between areas.

Public health input to local policies including the Statement of Licensing Policy, cumulative impact policies, and other alcohol initiatives such as Reducing the Strength programmes can be a valuable way to influence licensing at an area level. These policies can in turn then be used as resources to justify representations on individual licences.

Engaging closely and regularly with other RAs appears to be very important for PH practitioners’ influence over licensing and for their confidence to act on individual licence applications.

Some RAs and licensing stakeholders do not (currently) perceive much of a role for public health in acting on individual licence applications. However, in LAs with regular engagement between public health and other RAs, the RAs seem to value highly the perspective and inputs of public health, including supporting representations on individual applications.

**Room for improvement:**

- There are concerns from other stakeholders about the way that PH practitioners present evidence in representations, suggesting that they should not overwhelm the committee with too much evidence, and should present it in a way that is accessible for a non-specialist reader.

- Limited time and staff resources in public health teams, against a context of continuing budget cuts, means that alcohol licensing work is not always a priority, and some PH practitioners do not feel that the resources taken to make representations is justified by the typical outcomes. Other PH practitioners talk of the need to ‘pick their battles’, sometimes making compromises to balance time with the expected outcome of licensing work.

**Use and value of the SSLP licensing toolkit:**

While it was not possible to evaluated the impact of the toolkit on PH practitioners’ licensing work and their influence on licensing decision-making was not possible to evaluate, as explained in section 2.2, there were several findings that emerged from the ethnographic observations that highlighted the strengths and limitations of the toolkit among those working in LAs with access to the toolkit.
The data sheets were considered valuable for enabling access to postcode-level data on a range of types of variable (including crimes and ambulance call-outs), and allowing comparisons of number of incidents between wards, though not all practitioners used both sheets.

The visual representation of incidents in proximity to premises available through the ‘bullseye’ sheet was seen by some PH practitioners as a useful mechanism to communicate risk clearly in a representation.

The templates provided through the toolkit for recording information about applications and screening them according to specific priorities, and for drafting representations were in use and / or had been adapted by most PH practitioners, reflecting their local needs for capturing and communicating information.

The lack of updates to the data behind the sheets was a concern for some PH practitioners, but not all. Similarly, while a few PH practitioners felt the level of geographic specificity of the sheets (to 100m of a postcode) would not be strong enough evidence to present in a representation, others felt differently. This reflects the varied expectations across LAs for the nature and level of specificity of ‘evidence’ to support representations by licensing sub-committees.

Since the end of the study, regular updates to the data sheets have been resumed following a redevelopment of the database by the SafeStats team at GLA. The last update to the data was in December 2017.

4.2 Study strengths and limitations

The mixed methods approach of the PHAL study enabled us to explore different dimensions of the public health alcohol licensing contributions, from the day-to-day reality of screening and responding to applications, through the relationships and contexts in which these roles were situated, to perceptions and assessment of the influence of public health on licensing decision making. The study design also enabled us to engage with a range of different local authority areas (inner and outer London; those with and without strong night-time economies; varying levels of deprivation; different political compositions) and, to some extent, with public health teams with varying capacities to undertake alcohol licensing work. Consequently, while the focus of the study was limited to local authorities in Greater London, the variety of contexts, capacities and settings reflected in the sample suggests that many of the findings about the structures, processes and relationships that shape public health contributions to licensing may be transferable to other, non-London areas.
It is likely that the public health teams who participated in this study are those who are most actively engaged in the alcohol licensing process in their LAs, particularly the public health teams who had access to the SSLP toolkit, and those PH practitioners who participated in multiple stages of data collection. This indicates that our sample was likely biased towards those PH practitioners with more capacity to undertake alcohol licensing work, and the findings and recommendations from the study will be influenced by that. However, despite this bias, the range of perspectives captured in the study, particularly through interviews with licensing stakeholders from LAs with less (or no) public health licensing input, means that we have been able to explore and make recommendations for those teams who have little current engagement with the licensing process.

4.3 General recommendations

Against a backdrop of minimal political will for introducing a new health licensing objective into legislation in England and Wales, and with ongoing budget constraints and cuts across public health teams and all local authority departments, we recognise the need for pragmatic, minimal cost actions for increasing and strengthening public health contributions to the licensing process. The recommendations outlined in boxes 5 and 6 below reflect this.
**Box 5 Key recommendations for public health practitioners to strengthen contributions to alcohol licensing**

**Familiarise yourself with licensing policies, contacts and process**
For PH practitioners new to licensing work, getting to understand how the licensing process works in their LA, who the key contacts are among the other RAs and the content of other licensing policies (SLP, any CIPs etc) is important.

**Engage with other RAs**
PH practitioners should seek ways to maximise engagement with other responsible authority practitioners, whether through regular formal meetings, more informal catch-ups, co-located working or a combination.

**Build up evidence base for representations**
PH practitioners should seek to draw on a range of resources to justify representations and explore new opportunities for resources, including crime, A&E and hospital data; local and national research evidence; local residents’ inputs eg surveys; statements from ‘expert witnesses’ (eg local service providers); local policies including Statement of Licensing Policy and cumulative impact policies. Explore sources of data that can be analysed at postcode or lower super output area level.

**Influence broader licensing policy**
PH practitioners should actively seek to influence the development and revision of local policies, including SLPs and CIPs, to help build public health principles into the recommendations for licensing practice at the area level.

**Align public health priorities with other local priorities and policies**
PH practitioners should try to link the public health perspective with other priorities within the local area. For example, if there’s a regeneration strategy for the local area, it would be valuable to find evidence to justify a link between public health recommendations, improving local spaces, and promoting the local economy. Other local programmes or initiatives (such as a *Reducing the Strength* scheme) can be valuable resources to draw on as recommended conditions for licences and to justify representations.

**Communicate evidence clearly for effect**
PH practitioners should consider carefully how to present representations in order to communicate the evidence clearly and succinctly to a non-specialist audience. They could consider engaging with licensing sub-committee members to understand what they expect to see in representations and how they interpret evidence. Visual representations of data may be effective where appropriate.
**Share best practice**

Opportunities for sharing best practice for licensing work and examples of successful inputs among PH practitioners in different areas should be explored, for example through face-to-face meetings or online engagement.

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**Box 6  Recommendations for other RAs and strategic oversight of PH licensing work**

**Facilitate coordination between responsible authorities**

In light of continuing budget cuts, more efforts to coordinate the work of different RAs – including PH practitioners – should be undertaken, to facilitate the mutual support of RAs’ representations and to reduce unnecessary overlap and duplication of efforts.

**Build in strategies to retain knowledge and relationships in licensing process**

Processes should be established within public health (and other teams) to ensure the thorough handover of resources, understanding and contacts for undertaking licensing work to ensure continuation of knowledge and relationships through turnover or loss of staff.
4.4 Recommended steps to strengthening public health contributions to licensing

In addition to the general recommendations for practice and organisation of public health licensing work, it is important to consider the different stages at which PH practitioners may currently find themselves in relation to the licensing process, reflected in the study findings highlighting the great variety in amount of PH licensing work in different areas. Below is a three-stage pathway of steps, describing recommended actions to increase and strengthen existing levels of input to the licensing process: i) little no or current input. ii) some regular input, and iii) , from little or none, up to regular input. This pathway can be used to:

- Identify current levels of public health input and develop strategies to increase and strengthen it;
- Facilitate broader discussion among responsible authorities about the role of public health in the licensing process within a local authority, to develop understanding of the potential and value for public health contributions.

A pdf version of the graphic is available to download from: http://sphr.lshtm.ac.uk/phal/
Alcohol licensing
Key steps for strengthening public health contributions
A guide for practitioners from the Public Health & Alcohol Licensing (PHAL) study

Stage 1
Little/no public health input to licensing

1. Observe a licensing sub-committee hearing
2. Consult guidance resources & case studies (see resources box)
3. Identify and contact the licensing responsible authorities (RAs) for your local authority (LA) eg. licensing team, trading standards etc
4. Become familiar with your LA’s Statement of Licensing Policy (SLP) and any other local licensing policies

Stage 2
Some public health input to licensing

1. Identify ways to engage with other RAs eg. regular meetings, co-located working
2. Identify timescale & process for inputting to SLP and other LA licensing policies
3. Build up collection of different types of data and evidence to support representations (reps) eg. SafeStats data for London
4. Identify ways to prioritise inputs on licence applications eg. when to negotiate, when to submit a full representation

Stage 3
Regular public health input to licensing

1. Find ways to share licensing best practice with public health teams in other areas
2. Identify / develop local sources of data to support reps eg. local residents’ survey
3. Engage with council solicitor to understand licensing sub-committee decision making
4. Work with other RAs to develop other programmes / policies to support licensing process

Useful Resources
- For case studies see: full report from Public Health & Alcohol Licensing study [http://sphr.lahtm.ac.uk/phal/]
- For general guidance see: Safe Sociable London Partnership [www.safesociable.com/uploads-reports/]

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5 References


6 Appendices

**Appendix A:** Glossary of alcohol policies and programmes applied at the local level identified in this report.

**Appendix B:** Summary of study methods and sample.

**Appendix C:** Summary of analysis of licence applications received by public health
Appendix A – Glossary of alcohol policies and programmes applied at the local level

Below is a list and description of the various local alcohol policies, initiatives and programmes that were identified during the PHAL study. Some were referenced as part of conditions requested by public health in their negotiations and / or representations against alcohol licence applications, and others were mentioned as part of the broader alcohol work conducted by public health in LAs in London.

Statement of Licensing Policy:
A policy developed to set out how the local authority will apply its licensing functions under the Licensing Act. It can include a vision and priorities for the local area, and recommendations for how licence applications will be considered by the local authority. SLPs must be reviewed every five years or more frequently.

Cumulative Impact Policy:
Local authorities have been granted discretionary powers to designate areas of high saturation of alcohol-related activity as ‘cumulative impact zones’. A cumulative impact policy, within the Statement of Licensing Policy, sets out the local authority’s recommendations regarding any new applications or variations for licenced premises in these areas, for example the types of premises or hours of sale permitted. Under a cumulative impact policy, it is assumed that a licence application will be rejected unless the applicant can demonstrate that they will not add to the existing burden of alcohol-related harm in the designated zone.

Reducing the Strength initiative:
A voluntary initiative in which local authorities encourage licensees (typically shop owners with off-sales licences) to remove from their shelves beer and cider products with high alcohol by volume content (typically 6.5% or more). These ‘super strength’ beers and ciders are considered to encourage harmful drinking behaviours particularly among vulnerable populations.

Local Alcohol Action Areas:
A programme supported by national government but delivered at local authority level. Selected local authority areas are supported to deliver a locally-developed plan to address alcohol-related crime and health harms, in partnership with local agencies and businesses, and with the support of drinks manufacturers and retailers. 20 areas were selected in the first round in 2014, and 33 new areas selected in 2017.
## Appendix B – Summary of study methods and samples

The PHAL study included five different methods of data collection and samples, described below.

<table>
<thead>
<tr>
<th>Study method</th>
<th>Description</th>
<th>Total number participants</th>
<th>Further details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Ethnographic observations of PH practitioners’ licensing work</strong></td>
<td>Observations of PH practitioners: screening applications, writing representations, attending meetings / sub-committee hearings. Multiple observations over 8 weeks on average.</td>
<td>8 local authorities selected</td>
<td>5 inner London boroughs, 3 outer London boroughs. 6 LAs with access to SSLP toolkit; 2 without.</td>
</tr>
<tr>
<td><strong>2. Survey of PH practitioners’ licensing work</strong></td>
<td>Online questionnaire asking about amount of licensing work, actions and approaches, perceptions of influence</td>
<td>18 local authorities responded presented (all 33 approached)</td>
<td>11 inner London boroughs, 7 outer London boroughs. 9 LAs with access to SSLP toolkit, 9 without.</td>
</tr>
</tbody>
</table>
| **3. Focus groups**                              | 2 focus groups with PH practitioners; 1 with a group of RAs (including PH) from one LA; 1 group of licensing stakeholders. Included discussion of the PH licensing role and discussion of 3 licensing scenarios to explore how to strengthen PH inputs. | 37 participants in total. | FGD 01 and FGD 02: total 15 PH practitioners (from 14 LAs)  
FGD 03: 8 RA practitioners from one inner London LA  
FGD 04: 14 members of a national licensing stakeholder group |
| **4. Interviews**                                | Semi-structured interviews with a range of licensing stakeholders to explore perceptions of the PH licensing role. | 10 participants | 3 senior public health practitioners, 1 trading standards practitioner, 2 licensing practitioners, 1 police licensing officer, 1 regulatory services manager, 1 councillor and 1 barrister. |
| **5. Routine public health licensing data analysis** | Analysis of 9 months’ data collected by public health on licensing applications received, actions taken and outcomes of actions, between January and September 2017. | 5 local authorities | 5 inner London boroughs. 3 LAs with access to SSLP toolkit; 2 without. |
### Appendix C: Summary of analysis of licence applications received by public health in five LAs

**Table 5:** Summary of analysis of routine public health data on licence applications received in five London local authorities, January – September 2018.

<table>
<thead>
<tr>
<th>Individual local authorities</th>
<th>Combined LAs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
</tr>
<tr>
<td>Total number of applications</td>
<td>128</td>
</tr>
<tr>
<td><strong>Application type</strong></td>
<td></td>
</tr>
<tr>
<td>New</td>
<td>67</td>
</tr>
<tr>
<td>Variation</td>
<td>57</td>
</tr>
<tr>
<td>Review</td>
<td>2</td>
</tr>
<tr>
<td>TEN¹</td>
<td>2</td>
</tr>
<tr>
<td>Unknown</td>
<td>0</td>
</tr>
<tr>
<td><strong>Type of NEW licence requested (% of new applications &amp; TENS only)</strong></td>
<td></td>
</tr>
<tr>
<td>On sales</td>
<td>50</td>
</tr>
<tr>
<td>Off sales</td>
<td>12</td>
</tr>
<tr>
<td>Both</td>
<td>6</td>
</tr>
<tr>
<td>Missing</td>
<td>0</td>
</tr>
<tr>
<td>N/A</td>
<td>1</td>
</tr>
<tr>
<td>LNR</td>
<td>0</td>
</tr>
<tr>
<td><strong>Premises in application located in CIZ?</strong></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>43</td>
</tr>
<tr>
<td>No</td>
<td>82</td>
</tr>
<tr>
<td>Unknown</td>
<td>3</td>
</tr>
</tbody>
</table>

1 Temporary Event Notice. It is not a statutory requirement for public health as a responsible authority to receive TENs, unless the application is for an event with more than 500 attendees.

2 Action defined as negotiation with applicant and / or submission of representation, even if later withdrawn.

3 No action was recorded in LAi during the 9 month period of data collection.