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Innovation and diversity in public health team engagement in local alcohol premises licensing: qualitative interview findings from the ExILEnS study

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Abstract

Background: Evidence suggests that controls on the physical and temporal availability of alcohol can reduce alcohol-related harms. Public health teams in England and Scotland have in recent years been given a statutory role in licensing systems through which premises are granted permits to sell alcohol. The Exploring the Impact of alcohol premises Licensing in England and Scotland study examined public health team efforts to engage in alcohol licensing from 2012 to 2019.

Objective: We aimed to describe the range of public health team practice in engaging with alcohol licensing across England and Scotland, with a particular focus on unusual or innovative practices.

Methods: Two sets of interviews were conducted with 20 public health teams in England and Scotland who were actively engaged in alcohol premises licensing. Firstly, representatives of each public health team with experience of licensing activity took part in structured face-to-face or telephone interviews (n = 41) and provided documentation to identify how and when their team engaged with alcohol premises licensing. Secondly, members of public health teams took part in in-depth one-to-one interviews (n = 28) which focused on individual roles and responsibilities. Relevant public health team activity was analysed quantitatively within 19 activities in 6 categories using the 'Public Health engagement In Alcohol Licensing' measure, as well as qualitatively using NVivo (QSR International, Melbourne, Australia). Innovative practices were identified using the highest Public Health engagement In Alcohol Licensing scores for specific activity types across single or multiple 6-month periods.

Findings: Within each of the six activity categories, a range of practices were observed. More unusual practices included having a dedicated post to work full-time on alcohol licensing; developing a standardised reviewer tool allowing the team to respond to applications and provide the most relevant evidence in a consistent and systematic way; committing to additional scrutiny of occasional licences or temporary event notices; maintaining a detailed database recording applications made, whether the public health team decided to object and the outcome of the licensing board's decision; engaging with applicants prior to them submitting an application; visiting proposed/current licensed premises to gather bespoke data; leading the writing of local licensing policy; and working closely with licensing standards officers.

Conclusions: Across six categories of public health team activity relating to the local alcohol premises licensing system, public health team practices varied, and some public health teams stood out as engaging in more innovative or intensive activities. The identified examples will be of value in informing public health team practice in what remains a relatively new area of work for many, despite limitations in the system. The inclusion of examples from

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both England and Scotland and from many public health teams will facilitate cross-fertilisation of ideas and practice across public health teams.

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Introduction

Alcohol remains a major contributor to worldwide mortality and preventable disease. There is evidence from several high-income countries of a strong association between outlet density, alcohol-related harms and deprivation.[1,2] As a result, many countries require outlets to have a permit to sell alcohol, and in the UK, Scotland and England have slightly different licensing systems to administer this permit system. In both systems, local licensing authorities consider applications from premises for licences to sell alcohol for consumption on or off the premises. Applications must specify intended hours of sale, capacity and appropriate premises management, among other factors. Under separate licensing legislation applying in both systems, there are explicit licensing objectives set to guide decision-making: (1) to prevent crime and disorder, (2) to promote public safety, (3) to prevent public nuisance, (4) to protect children (and in Scotland, young people) from harm and (5) in Scotland but not England, to protect and improve public health.[3,4]

In both countries, locally funded public health teams (PHTs) have in recent years been added to a list of 'responsible authorities'/'statutory consultees' (including police and other public sector bodies) that by law must receive notice of local alcohol premises licence applications, so that they can choose to review the application in the context of the above objectives. Decisions regarding these licences are then taken by a committee comprised of elected representatives from the local government. Licensing committees set policy, including overprovision or Cumulative Impact Assessments (CIAs). The form and powers of these committees differ somewhat between England and Scotland.[5]

Local licensing boards must produce a 'Statement of Licensing Policy' (SLP) every 4–5 years and are required to consult publicly on their proposed policy. In Scotland, SLPs must include a statement on 'overprovision'; that is, whether there are areas in a board's jurisdiction where the number, or density, of outlets of any type is deemed excessive. In such areas, applications may be refused solely on grounds of overprovision. In England, a provision exists whereby licensing authorities may conduct CIAs to determine whether there is evidence to show the type or number of premises is having a cumulative impact and undermining the licensing objectives. In both overprovision and cumulative impact areas, the burden of proof regarding the licensing objectives is reversed: applications are expected to be refused unless they demonstrate that to grant the licence would not undermine the objectives. The law and guidance on overprovision areas in Scotland is broader and stronger than that of CIAs in England.

A small number of studies have examined PHT practice in this field, although this research has tended to focus on single cities or nations.[6,7] Reynolds *et al.* conducted research across 24 local authorities in Greater London and observed public health practitioners working through licence applications, exploring data sources and drafting representations against applications.[8] This study found that the type of work undertaken in relation to alcohol licence applications varied considerably across the sample with some PHTs more actively involved in licensing due to differences in capacity. Differences in screening procedures were also identified, with some PHTs having a set of explicit criteria or priorities against which they screened applications and recorded information on each on a detailed spreadsheet. A study by Somerville, Thom and Herring focused on PHTs in six London boroughs and observed variable engagement in partnerships between PHTs and other responsible authorities.[9,10] This study observed variation in how involved the PHTs became in the licensing process, with several areas believing that public health should take a supporting role to other responsible authorities. Partnership working was believed to be key to influencing licensing decisions; however, PHTs often found it difficult to establish these partnerships, as they felt their way of working and the type of data they worked with differed greatly from other responsible authorities. Fitzgerald *et al.* interviewed various 'public health actors' in eight health board areas in Scotland in 2013–4 who had recent experience of engaging with local licensing boards and also found that their work included responding to individual applications, responding to and monitoring licence applications and objections, collaborating with colleagues in health and policing, regularly presenting at licensing board meetings and the collation of data on the harms of alcohol to support the development of new licensing policies and licensing board decisions regarding whether or not to declare an area to be overprovided.[11] One area had started to monitor licence applications and objections, but this was not common practice across the areas included in the study.[11–13]

None of the above studies systematically examined PHT practice and were either limited in scope in terms of the number of PHTs included or in their geographic focus. The ExILEnS study (Exploring the Impact of alcohol premises Licensing in England and Scotland, NIHR PHR 15/129/11) developed and applied a novel measure of PHT activity in 39 PHTs in England and Scotland and found wide variations in involvement across 19 types of relevant activity in 6 categories.[14] The findings suggest an opportunity for cross-fertilisation of ideas and practice among PHTs considering how to engage with alcohol premises licensing. Such cross-fertilisation is known to be important in the diffusion of innovation and knowledge relevant to local public health decision-making and alcohol licensing decisions.[15,16] Despite PHTs having a long-standing role in alcohol licensing in England and Scotland for over a decade, no previous study has examined PHT practice in engaging with licensing across a large sample of local authorities in both nations.

The ExILEnS study has previously reported in detail on seven key differences in practice found between PHTs in Scotland and England: (1) earlier engagement in licensing by Scottish PHTs; (2) a step-change in activity levels in England in 2014; (3) a greater focus on inputting to local licensing policy statements in Scotland; (4) greater involvement of senior public health leaders in Scotland; (5) greater diversity of activity around responding to licence applications in England, including a greater tendency to negotiate conditions on licences with applicants; (6) PHTs in Scotland being more willing to submit their own objections to licence applications even if unsupported by other responsible authorities such as the police; and (7) Scottish PHTs involved the public more in licensing process, partly because of statutory licensing forums there.

This current paper aims to describe the range of PHT practice in engaging with alcohol licensing across the included PHTs, with a particular focus on describing unusual or innovative practices in detail.

Methods

This paper draws on data gathered through both structured and in-depth interviews with PHTs conducted in person or by telephone over the period 2018–20 reported in line with the consolidated criteria for reporting qualitative research requirements.[17]

Sample and recruitment of public health teams

In accordance with our protocol, we purposively sampled 20 PHTs (14 in England and 6 in Scotland) who had been actively engaging with local alcohol premises licensing in recent years.[18] Recruitment took place from 2017 to 2019. To gain this sample, all PHTs in England and purposively selected PHTs in Scotland were informed about the study by e-mail and invited to express interest in taking part. Telephone calls with interested PHTs scoped their level of engagement in licensing, and this information was used along with advice from Alcohol Focus Scotland (AFS) and Public Health England (PHE), published reports and case studies to select the final sample of PHTs and ensure they varied in terms of region and rurality.

Data collection and recruitment of individual interviewees

Two sets of interviews were conducted with the 20 active areas. First, available representatives of each PHT with experience of licensing activity within the time frame of interest (1 April 2012–31 March 2019) were identified through direct contact, site visits and snowball sampling to take part in one or more largely structured face-to-face or telephone interviews (total $n = 41$). Those interviewed included public health practitioners, alcohol strategy leads, consultants in public health medicine, Alcohol and Drug Partnership (ADP) co-ordinators, directors of public health and alcohol harm reduction teams. The purpose of these structured interviews was to describe and explain PHT activity in engaging in alcohol premises licensing. The interviews were structured according to categories contained within an early version of the Public Health engagement In Alcohol Licensing (PHIAL) measure described in full elsewhere.[14] These broad categories were resources for PHT activity to influence local alcohol licensing; internal process for monitoring alcohol licensing and reviewing alcohol licensing applications; shaping and responding to licence applications; analysis and use of routine or bespoke data; efforts to influence the development of local licensing policy and stakeholders; engagement with public and wider stakeholders; and engagement/initiatives with alcohol licence holders.

Structured interviews lasted between 22 and 211 minutes (median length: 83 minutes) and were audio-recorded with participant permission and transcribed in full. Structured interviews were conducted by AM, NM, RP and NF. Before the interviews, each PHT also provided supporting documentation such as databases, letters of representation or objection, responses to consultations, draft or final statements of licensing policy and so on. This documentation was organised according to the categories above and used to inform the structured interviews. Further documentation was provided following the interviews. Documentation was used to support the grading of PHT activity for each area (see below).

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Second, members of PHTs in all 20 areas took part in in-depth one-to-one interviews (n = 28) focused on why they engaged in licensing in the ways that they did. Twenty-four individuals who took part in in-depth interviews had also taken part in one or more structured interviews (8 participants based in Scotland, 16 based in England). These interviews lasted between 36 and 156 minutes (median length: 73 minutes) and were audio-recorded with participant permission and transcribed in full. Conducted by RO, AM, NM and RP, the interviews included a focus on interviewee roles, responsibilities, approaches and purpose in the licensing system. Sampling of individuals focused on ensuring that at least one interview was conducted in all 20 recruited higher activity areas, in accordance with our protocol, and was purposive to optimise diversity in terms of the remit and role of the interviewee.

Data analysis

Both sets of interview recordings were professionally transcribed, anonymised and imported into NVivo 12 (version 11.0.0.317, QSR International, Melbourne, Australia) for analysis.

Anonymised transcripts of structured interviews and all relevant documentation obtained were coded in NVivo by RP, AM and NM, each primarily responsible for data from specific local areas. The structured interview data were reviewed to identify the nature and timing of different activities undertaken by PHTs. The data were then used to further develop the PHIAL measure, which defined and described 19 activity types in 6 categories. The PHIAL measure included a grading system for each of the 19 activity types (e.g. high/medium/low), which were translated into scores. The PHIAL measure was applied to each of the 20 areas separately, by reviewing structured interview data and documentation to grade and score the 19 activity types for every 6-month period. A full account of the PHIAL measure development is available in Fitzgerald *et al.*[14]

The in-depth interview data were analysed by RO using a reflexive thematic analysis approach (described in full elsewhere).[19] For this paper, the in-depth interview data were drawn upon to provide further insight and detail on the 19 activity types in the PHIAL measure.

The choice of examples included in this paper was guided by the scores for the 20 PHT areas for the 19 activity types included in the PHIAL measure. The PHT areas with the highest scores for a given activity type across single or multiple 6-month periods were identified by RP. For these areas, RP then reviewed the structured interview data in detail to select, in discussion with NF, AM and RO, the most illustrative and interesting examples to report here for each activity type. The resulting descriptions of practice examples were based on the structured interview data and our knowledge of the accompanying documentation for each PHT area, while accompanying quotes from in-depth interviews selected by RO were used to provide additional insights and detail. All authors reviewed the selected examples and provided further input, where possible, based on their knowledge of the data set and context.

Public and stakeholder involvement

As a study of PH practice in the licensing system, the public audience for the study is primarily PHTs and licensing teams across the UK rather than members of the public. We therefore paid a lot of attention to ensure that these stakeholders were adequately involved in the research. Firstly, representatives from the UK licensing and public health network and Alcohol Focus Scotland (AFS) joined our team as coinvestigators/coauthors, alongside a retired local authority practitioner with experience of licensing (based in England), all contributing to team meetings and thinking throughout the study. Secondly, on our Study Steering Committee (SSC), we benefited from the expertise of the lead for licensing from Public Health England (PHE), two licensing lawyers (one based in Scotland and one in England) and a public health practitioner with experience of licensing (based in Scotland). We also involved two members of the public, who sat on the SSC, contributed to the design of the study and data collection methods but who were not available to contribute directly to this paper.

Results

We describe the range of PHT activities below in context, highlighting specific examples of practice within each of the six categories of activity identified in the PHIAL measure.[14] For each category, we first describe the most common or routine type of activity across the sampled areas before presenting the specific example of unusual or innovative practice. More detailed examples of unusual or innovative practice are described in full and included as appendices.

Category 1: Staffing for public health team activity to influence local alcohol licensing

In most areas, the extent of time input into licensing by senior leadership (such as through attending licensing-related meetings, or participating directly in appeals) was limited. The role of senior leadership in some areas included attending or chairing regular strategic meetings with other responsible authorities/statutory consultees that included

a licensing component, such as community safety-related fora. In some areas, senior leadership would meet with staff to discuss potentially problematic applications, or to instigate broader changes of internal licensing processes. Typically, there would be either a single public health professional (such as a health improvement officer), or a rotation of people with day-to-day responsibility for alcohol licensing, often alongside other responsibilities not related to alcohol licensing.

However, in some cases (usually in larger metropolitan unitary authorities), the staff member responsible for alcohol licensing was working full-time, or close to full-time, on alcohol licensing and other alcohol-related issues (see *Appendix 1*). Developing specialist knowledge and expertise was described as a key part of the role.

The bulk of PHT resources allocated to licensing work was made up of staff costs; however, a small number of PHTs committed funding to develop networks, access licensing-related data sets or to set up licensing screening tools incorporating available data sources.

Category 2: reviewing alcohol licensing applications

New licence applications

Processes for reviewing new alcohol licence applications or variations to licences were extremely varied across the sites included in this study. As statutory consultees/responsible authorities, PHTs routinely received notification of new applications and applications for major variations of licences from the licensing team as they came in. These notifications were usually sent by e-mail to a shared mailbox, and these mailboxes were sometimes checked on an ad hoc basis, depending on when applications were received, or in other cases, checked weekly. There is no prescribed approach for statutory consultees or responsible authorities to execute their role. For most PHTs in Scotland and England, the process for reviewing new licence applications evolved over time from when health authorities were first given a statutory role (2011 in Scotland, 2012 in England), as experience, partnerships, expectations and data availability evolved.

In some cases, PHTs had developed a tool to review licence applications to inform their response to each application. This could include checking responses from partners; whether the application was located in a Cumulative Impact Zone (CIZ) or overprovision area; whether the application adhered to the requirements in the local SLP; and possible options for mediation with the applicant in co-ordination with the local licensing team. It might also combine many of these aspects with harm indicators. The team in one area in London and South East England (Area 33) felt that they needed a standardised process to review applications. They developed a reviewer tool that allowed the team to respond to applications and provide the most relevant evidence in a consistent and systematic way. This was an innovative approach to reviewing new applications and stood out from the other areas who took a more ad hoc or reactive approach. The licensing reviewer tool combined various indicators such as whether the application was in a cumulative impact area, the numbers of premises nearby, ambulance callouts and alcohol-specific admissions to hospital. These data were contained in one place to save the team having to look at each indicator separately or in separate spreadsheets. Although the data relevant to specific applications varied slightly, the tool allowed the team to take a consistent approach when responding to applications. This team felt that developing 'triage tools' for licensing was a positive and important part of the PHTs' role.

In other cases, the PHT took a more reactive approach to responding to applications, based on what applications were being discussed at responsible authority fora:

> *So from my perspective the way I've tried to learn the ropes is to keep an eye on cases that are being discussed at the responsible authorities' meetings which are, if anything would end up at hearing the first time you'd hear about it would be in one of those multiagency discussions … what I do is I try and keep notice of cases that are coming up and will supply evidence to support other responsible authorities in bringing hearings [a representation or objection by the PHT would result in the application going to a hearing] which by definition is few and far between.*
>
> *PHT, Area 24, England*

This reactive approach was employed to limit the amount of time spent working on responding to applications given the limited capacity of PHTs to engage in this work alongside other responsibilities.

Applications for one-off or temporary increases in availability

The ways in which PHTs approached reviewing and responding to applications for temporary increases in alcohol availability was also extremely variable, reflecting the limited resources and staff available, limitations in the amount of evidence they could gather and perceptions of the likely impact of the proposed application. In England, temporary event notices (TENs) can be applied for to sell alcohol at an otherwise unlicensed venue, but

the Licensing Authority cannot refuse a notice unless the police or environmental health object to it (PHTs do not have the right to object). In Scotland, an occasional licence allows alcohol to be sold on unlicensed premises for a specified period, and applications are sent to Police Scotland and the local licensing standards officer (LSO) for review, who both have 21 days to respond to the licensing board, though anyone can make an objection.

Public health teams were therefore not routinely informed of applications for one-off events and had to rely on this being agreed with other partners such as the licensing team or the police. One unusual example of engaging with licensing came from an area in South West England where the local economy was very seasonal and tourist based. Therefore, the PHT, alongside other responsible authorities, committed to additional scrutiny of occasional licences or TENs (see *Appendix 2*).

In North East Scotland, one PHT also described how it was difficult to respond to applications for occasional licences, as they had a shorter time frame for submitting a representation or objection than full licence applications. This motivated the PHT to seek to influence licensing policy as explained here:

> *We are not notified automatically about occasional applications. We have got to go in and check the council website and then we have to phone and get more information about the application. So it's a much more time intensive approach and we only have seven days to respond and we are often missing the deadlines …. We did a SWOT analysis about how to take this forward for the occasional licenses and it was decided that really, the best approach would be to somehow influence the statement of licensing policy and have more defined controls in the statement of licensing policy and that would maybe help us.*
>
> *PHT, Area 32, Scotland*

Monitoring responses to applications

Public health teams had varied actions or processes used for keeping track of the number and type of alcohol licensing applications received, and/or applications responded to by the PHT, the rationale for the response or outcome of such applications. Some areas reported that they only logged the number of applications received on a simple spreadsheet, whereas other areas maintained a database of applications received, responses made and the outcome of the application. Areas that kept particularly detailed databases would also include additional intelligence, including the reasons for the licensing board's decision, any areas that require further action from the applicants and notes that may be of use for the PHT to consider when reviewing future applications.

One PHT maintained a very detailed database, which recorded the applications made, whether the PHT decided to object or not object, and the outcome of the licensing board's decision. This database also recorded additional intelligence, including if there was an element of negotiation involved with the applicant, meaning that conditions had been agreed between the PHT and the applicant before it went to the committee hearing stage, thus removing the need for the PHT to formally object to the application at the hearing stage. Capturing this level of information allowed the PHT to keep a record of their level of involvement in each application and any discussions they may have had with other responsible authorities regarding the applications.

> *So, yes, as the applications come in, they get put on a spreadsheet and, yes, as you say, is a rota. So, we take turns in taking the applications. So we monitor the responses that we put in and update the database with the outcomes of reviews or what we've done … It goes on the same spreadsheet. So, we are able to monitor it. In fact, before (previous team member) left he did do a little audit of it [the spreadsheet] and actually made a few little changes to the spreadsheet as a result of that … The issue that we came across in terms of kind of monitoring is capturing in a meaningful way what happens in an application because I'm sure, as you're aware, there's very often an element of negotiation. So, in terms of monitoring it, it did used to be either object or not object and now we've added in another option which is negotiation.*
>
> *PHT, Area 39, England*

Category 3: influencing and responding to individual licence applications

Influencing applications prior to submission or decision

Many PHTs did not proactively engage with potential applicants prior to them applying for a licence. However, there were exceptions to this in some areas, where applicants would approach the PHT in advance of submitting an application to ask what sort of response they could expect from the PHT if they were to apply for a licence.

In one example, representatives of a premises would often get in touch with the PHT to say they were thinking of applying to extend their opening hours and whether the PHT would object to their application. If the area was in

a CIZ, then the PHT would inform the applicant that they would have to put in an automatic representation due to the CIZ. Sometimes this process resulted in the premises changing their mind about applying for a variation.

> *We could knock them back and much to the chagrin of the applicant and their cost as well, but we don't, we genuinely offer support to them to get them to a stage where they can operate, not only a profitable business but a responsible one. And that's our, that ends up with us doing the work to get them there because actually we probably, we don't want empty shops, I don't want empty shop fronts, I don't want closed businesses, and our city needs economic growth quite massively.*
>
> *PHT, Area 30, England*

The PHT would also offer feedback on applications before they were formally submitted to the licensing committee, asking the applicants to improve their application by adhering to certain conditions and warning them that if they submitted it without these conditions, they would risk the PHT objecting to the application. This was not standard practice for all applications and was offered at the discretion of the PHT because of the enthusiasm of one particular PHT member:

> *The standard [form] for applying for a premises licence has five boxes on it and it says, in the boxes, please outline the steps you would take to promote the licensing objectives starting with a general [box for] all four objectives. Now three times this year I've received applications that have basically just had the licensing objectives written in that top box again. So, they've literally just replicated the list that appears below in that box and then in the other boxes they've written just, and we will obey all local and national fire safety legislation in all four of the boxes. Things like that whereby all rights we should really send them back and say that's not a good application, but my first thought when I get that application is to go back to them and say can you think about this or would you take these as conditions or try and explain a little bit more. And that's probably because I've got a passion for licensing and I believe we can do something good with it.*
>
> *PHT, Area 30, England*

The practice of liaising with applicants once they had submitted their application with a view to the applicant ultimately amending the application was relatively common among active PHTs, though mainly in England. In England, examples of PHTs liaising with applicants or their solicitors were not particularly unusual, and the primary request of the PHT was that the premises agreed to additional voluntary conditions on the licence. In some cases, this process was co-ordinated:

> *So we receive the application. [Analyst] does the analysis, pulls together what we could put a representation on and then on the basis of that, I review it and any particular issues. I then contact the solicitors directly, because we have got all their details and I put forward, basically, this is what we're going to send as our representations, but we'd prefer if you'd consider them so that we don't have to put the representation in. And then it's just a back and forth really, if I'm being honest.*
>
> *PHT, Area 16, England*

However, the majority of PHTs in Scotland did not feel it was appropriate for them as health representatives to directly interact with licence applicants or their representatives due to their conflicting interests (see Fitzgerald *et al.*).[5]

In Scotland, all new/major variation applications must be considered at a routine licensing board meeting regardless of whether an objection is submitted. This meant that there was less incentive for Scottish PHTs to engage with applicants before the licensing board meeting. Engaging with the applicant was viewed as part of the role of the LSO. As one Scottish PHT put it,

> *No, we don't have anything to do with the applicants at all. The LSO's do that, it's their job. Again it's the job of the LSO's to sort out anything really unsuitable and negotiate with people.*
>
> *PHT, Area 37, Scotland.*

In Scotland, licensing boards can include mandatory conditions in the SLP, which are then applied to all licence applications. These must be justified with robust evidence and included in the policy. This was different from in England, but several PHTs in England reported that they would ask applicants to place voluntary conditions on their applications. One area in England reported the success they had in asking applicants to include certain conditions as part of the application process alongside the legal requirements to obtain a licence. These conditions were asked to be included after the applicants submitted their initial application but before the hearing took place. This PHT worked with the licensing team to ensure the conditions were worded correctly. For example, they asked for conditions regarding restricting the sale of certain high-strength products such as lagers, beers and ciders above 6.5% alcohol by volume (ABV). Applying conditions to applications had reduced the number of objections the

PHT had to make at the committee, reducing the amount of time the PHT had to spend preparing objections or attending committee hearings.

> *I think we've had a number of successes where we've managed to get licensed properties to include restrictions on the sale of high strength drinks. We've had several of those … including a large-scale distillery here which … to be honest we felt we needed to put some conditions on because of where it was located … we didn't really think they were going to agree to anything but we just put it in in hope. But they did actually work with us very closely and negotiated some slight wording changes but it, we did get the high strength thing in there.*
>
> *PHT, Area 16, England*

Submitting representations or objections to licence applications

All PHTs actively working on alcohol licensing made representations/objections to the licensing board to some extent; however, these efforts varied significantly in terms of the depth and breadth of supporting evidence used, and the thresholds in place to trigger a representation or objection.

Representations can be in support of an application or can propose modifications to the operating plan or conditions to be attached to the licence. This could involve local licensing policy documents, the presence of a recognised cumulative impact or overprovision, data on alcohol availability or harms, the support of other responsible authorities or local knowledge. There were also differences in the degree to which a representation was co-ordinated with other responsible authorities/statutory consultees, the extent to which the licensing objectives or SLP was referenced, and the extent to which they were based on standard proforma text or customised. In at least one case, standardised text representations/objections submitted by the PHT were dismissed by the local licensing board, as they were not tailored to specific applications.

An objection is different from a representation in that it involves stating opposition to the licence application being granted, rather than supporting or seeking amendments to it. PHTs often described how they learnt from early efforts to object to applications, leading to more nuanced or tailored approaches on how and when to object developing over time:

> *When I first came into post and we started this process, I wasn't quite as smart on the objections and representations. We objected to everything, when in effect, it was actually a representation. We have evolved ourselves in how we've been managing this process … we've tailored it more to the areas, because the board were asking for more detailed information that related the premises to the community.*
>
> *PHT, Area 32, Scotland*

If an application was received for a premises licence in an area designated as having high alcohol density, such as a CIZ) (as was in England) or an overprovision area under Scottish law, this was an important 'trigger' for representations/objections. In several cases, PHTs would only consider making an objection or representation where the application was in a CIZ or overprovision area. In these cases, it was up to the applicant to demonstrate why the application should be granted, and not on the objector to make the case why the application should be rejected. In other words, the burden of proof was reversed. Having a CIZ in place was felt to be particularly important in England, where there was a sense that at times public health was regarded with suspicion or doubt by the licensing system in the context of representations, facing frequent objections from licensees and their legal representatives. Often, this was linked to the lack of a specific public health objective among the licensing objectives in the law.[20]

Public health teams being involved in applicants' appeals against decisions was unusual, sometimes due to negative past experiences. For example, one PHT recalled how their first experience of being involved in an appeal had a profound impact on how the team approached future involvement in licensing, both due to perceived cost burden of such legal procedures to the local government, but also due to perceptions their evidence was not sufficient in a legal sense:

> *[An application was] rejected by the licensing but it [the rejection] was challenged by the licensee … And then it went to court from that …Yeah, I think that was it and that's when my job had changed … and actually the amount of time it was taking and if we were going to get challenged because we were having to go to hearings, so not only do you have to prepare your representation, you're then waiting and then you have to spend half a day at a hearing because you don't know when you're going to get on. They [the licensee] challenged the evidence that the police had given and the evidence that the Trading Standards had given, but based on what the court then said it was all, again it almost felt like their decision [the court] was just ignoring our evidence.*
>
> *PHT, Area 21, England*

Category 4: use of routine or bespoke data on alcohol licensing and alcohol-related harms

All PHTs actively involved in licensing relied on the collation or analysis of existing data sources to inform their work. This included generating geographic profiles at the neighbourhood or authority level summarising statistics on alcohol-related harms and outlet density, and the use of other indicators such as crime, accidents, domestic abuse, sexual assaults, hospital stays for alcohol-related harm or ambulance callouts.

In some cases, these data were used in presentations to stakeholders such as councillors or other responsible authorities/statutory consultees. Most commonly, the data were used to inform representations in response to licence applications, or to support submissions to consultations for new licensing policies or overprovision policies or CIAs. In many cases, the way in which data were used was continuously evolving in response to the needs of partners in the licensing system.

In some instances, the data gathered by the PHT proved useful to other responsible authorities. For example, one PHT described how the police had submitted a review of a premises as they were concerned it was going to be used by football fans who they believed were likely to cause trouble in the town centre after the match. The PHTs were able to show that violence and accident and emergency (A&E) admissions due to assault and violence and alcohol went up on match days:

> *… we normally get notified by licensing [of representations or reviews] but the police would be in touch with me beforehand saying this is the score, we're going to submit a review, is there anything that you could help with? So then I went away and had conversations with the [analysts] and said is there anything that we can get from A&E data to show was there an increase in hospital admissions around the time of the football match on that particular day? How does that compare with other football match days? Was there any sort of significant increase? What were the injuries of people attending? Could we sort of look at the crime data and the hospital admissions to put them together? So that's the type of thing, yes …*
>
> *PHT, Area 38, England*

A recurring perception of PHTs was that licensing committees were critical of public health data as not being premise-specific and therefore insufficiently precise to inform licensing decisions. This was cited by PHTs, especially in England, as a reason for not getting more involved in making representations, particularly if the PHT would be the only responsible authority to do so. However, PHTs, particularly in Scotland, reported some successes in influencing licensing decisions using area-level health and deprivation statistics. However, they felt that objections that featured a combination of health data and individual stories were most successful. One PHT in the West of Scotland (Area 31) had a team of analysts who compiled data on an annual basis for their area and summarised it for each of the licensing board areas that they covered. This included detailed information on emergency admissions to hospital, deaths, alcohol-related brain disease and mental health discharges (see *Appendix 3*). Some PHTs also used routine data to rank small areas in terms of availability and harms.

The kinds of evidence used to support representations was therefore not limited to statistics, and some PHTs reported going out to the location to which an application related, to observe and record relevant features of the area:

> *… they [representations] took a lot of time because part of the evidence process is me actually going out and walking round and looking and seeing for things like litter, street drinking. … I go in and I actually speak to people and talk to them.*
>
> *PHT, Area 36, England*

One PHT mentioned specifically focusing on seeking to have applications for off-licences rejected due to the levels of associated alcohol harm. This involved gathering evidence from local businesses and those affected by alcohol misuse.

> *I contacted local businesses around the area, like there was a nursery and, just to ask them, I wasn't in any way, I wasn't trying to persuade them, I was just saying, this is what's happening, there's going to be an off licence potentially opening on your doorstep, have you been affected by alcohol misuse, if so how? Do you, does it matter to you if another place opens? And often they said, yeah, it does, we are affected.*
>
> *PHT, Area 21, England*

To inform representations and policy submissions, several PHTs went even further and tried to develop new bespoke or expanded data collection processes such as data-sharing agreements with local A&E departments.

One area in London and South East England reported how they had used a survey of local residents to help gather evidence for their SLP, but this was only used on one occasion.

> *I only really used the residents survey for the SLP evidence proposal, I have used it once in a licensing application immediately afterwards, that, from review, that was a review of an off licence. But it, I didn't feel it was that successful so I haven't used it since then*
>
> *PHT, Area 20, England*

Occasionally, PHTs gathered new qualitative data through site visits to local areas, speaking to local residents and licensees, and taking photographs (see *Appendix 4*).

Category 5: influencing local stakeholders or licensing policy

Influencing the local SLP was widely seen to be the most 'cost-effective' or 'important' way of influencing licensing by PHTs and was something that Scottish PHTs had been highly engaged with from the start of our data collection. These two quotes from PHTs in Scotland explain their activity and the thinking behind it:

> *… I have also been heavily involved in producing data to support the development of policy, which I believe to be the most important thing. I think what you do with your letters [objections] along the way is tinkering around the edges. The most important thing is getting the policy right in the first place, because if the policy is right, the Board should be making the decisions with Public Health in the front of their mind anyway, so you shouldn't need to object, because the policy should be robust enough in terms of overprovision.*
>
> *PHT, Area 37, Scotland*

> *… we [Public Health and ADP], prepared a briefing report for the Licensing Board, which described the public health and social impact of alcohol availability in the city … our recommendation to the Licensing Board was that, in order to reduce public health harm going forward, that no new off-sales, so new premises that were seeking an off-sales licence, the presumption should be against issuing an off sales licence … following consultation from the Licensing Board, they looked at various options but they looked at on and off-sales provision, but they decided that they would adopt an overprovision policy statement … without that kind of robust backing and kind of proactive setting out of our position, there was a period in which we were not challenging alcohol, objecting to alcohol licences, because we felt it was so imperative to have that policy statement laid out, because that makes it much easier for us then to say, look, there has been a consultative process, this is the position that the Licensing Board has adopted and recognised as important, and therefore it gives us the strength and the power to object to licences, of off-sales, going forward.*
>
> *PHT, Area 28, Scotland*

This approach to limiting availability and generating a longer-term culture change involved broadening licensing decision-makers' understanding of alcohol-related harms to health by actively seeking to raise the profile of long-term health harms caused by alcohol in discussions of local licensing policy or decisions.

Public health teams attempted to influence the SLP by supplying data to inform the policy or responding to policy consultations. In several English PHTs, this was also viewed as critical to PHTs having greater involvement in licensing decisions, as their subsequent objections could be linked back to the licensing policy. In one case, the PHT was influential enough to be tasked with leading the drafting of the SLP itself (see *Appendix 5*).

More generally, relationships between the PHT and the local authority licensing team varied greatly. Some PHTs had almost daily contact with the local licensing team (see *Appendix 6*).

Category 6: engagement with or involvement of the public

Most PHTs acknowledged that there were challenges in engaging the public in licensing in terms of resources, but many felt it was important to inform the public on their rights regarding alcohol licensing decision-making and to gather evidence to support the public to input to decisions. PHTs active in this way reported benefits from it, either in building support within the licensing committee for public health arguments or in helping to gather information to support specific objections that the PHT was preparing. PHTs gathered information from the public either through surveys or direct outreach. One PHT described how they consulted with various community groups to promote participation in a local public consultation on alcohol licensing.

> *During this public consultation period we've gone to various forums and PACT (Police and Communities Together) meetings … Yeah. Just to try and promote the public consultation part to talk about the policy, why it's important … town centre forums, so business forum … I consulted with a lot of the PACTs actually about the CIP [cumulative impact policy] [more] than I have done about the [statement of licensing] policy … because it was that tight three-month deadline [for the SLP] they don't all meet and so it was difficult. But I consulted*

> *with the public more for the CIP, which is how I got the feedback I did for the public consultation questionnaire thing. Because there's no use just sending these things out, you need to stand in front of people and shout at them to reply, please reply.*
>
> *PHT, Area 36, England*

One Scottish PHT engaged with members of the public through various events, including one that was a collaboration between PHT, the LSOs, the local ADP and the local licensing team. This involved a two-part workshop to explain the licensing process to community councils to empower them and give them confidence in how they could be a part of the licensing process. This training was developed in conjunction with AFS (one of Scotland's national alcohol advocacy organisations).

> *I think, for me, the learning that I've had over the past few years is that you've got to be really clear about the purpose of involving the community and engaging them in this process. So one of the things that we did … was spend quite a bit of time working with community councils and training them in the licensing toolkit produced by Alcohol Focus Scotland. And there are some community councils that are very active and they contribute a lot to the licensing process. I think that's down to individuals as well – not necessarily their particular view about alcohol but their confidence and ability to engage with the process and represent their community at the licensing board.*
>
> *PHT, Area 32, Scotland*

Discussion

This research is the largest study to capture in detail PHT activity in relation to alcohol licensing across England and Scotland.

The findings here demonstrate that despite PHTs being enabled to engage with alcohol licensing since 2011, it is still an evolving role for many.[9] Often, the processes and systems have evolved since PHTs first became a responsible authority. Indeed, our findings point to several aspects of the role, such as reviewing applications, changing over time as staff experience, partnerships and data availability evolved. Many PHTs adapted their approach, moving from presenting the evidence based on alcohol availability, consumption and harm; to a more nuanced, tailored approach, recognising the practical reality that licensing is about achieving limited goals, working incrementally and developing partnerships. Further work from the ExILEnS study explores this shift from a 'challenging' approach to a more 'collaborative' approach over time, which focused on joined-up working with licensing teams.[19] In some cases, licensing stakeholders spoke of a 'bedding in' process, where they invested time in training PHTs until they possessed the knowledge and experience licensing stakeholders believed necessary to effectively engage in the licensing process. Reflecting the longer time period of data collection and the wider geographical spread, the findings from our interviews suggest that PHTs active in alcohol licensing have adopted a much broader range of approaches to influencing licensing to overcome some of the challenges indicated in previous research than previously reported in terms of resourcing, processes, responses, data collection, making representations, impacting on policy and licensing stakeholders and engaging the public.

The diversity of approaches reported by the PHTs in this study often arose because of the cultural, practical and operational difficulties, and unclear, complex power dynamics within the policy-making environment between the different local government departments (despite the presence of licensing objectives) that PHTs have found difficult to navigate.[7,9,11–13] PHT practice evolved and adapted to the challenges they faced.

Those PHTs who worked closely with licensing colleagues stated that it took time for the mechanisms to be put in place to strengthen relationships. This was addressed, in part, through dialogue and training between the PHT and licensing colleagues and members of the licensing committee. Previous research has pointed to the lack of a public health-focused licensing objective for English PHTs, meaning they have often been required to adopt a pragmatic approach to partnership working.[8] This is borne out by our findings here, which demonstrate the range of approaches taken by PHTs across England and Scotland to build relationships with other stakeholders. Most agreed that this was essential in strategically positioning public health to influence licensing decisions in favour of public health outcomes.

Egan *et al.* have previously described supportive and critical framings of diversity in local policy.[21] Supportive framings suggest that variation is inescapable given the complexity of local government, but also that adaptation to (changing) local contexts may help maximise effects and sustainability. Critical framings often focus on the difference in health (or other) benefits that result from local policy variation – generating area-level inequity sometimes referred to as 'a postcode lottery'.[22] While Egan *et al.* focused on Cumulative Impact Policies (CIPs), the current study identifies variation across a wide range of PHT activities related to alcohol licensing

more broadly. Nonetheless, the same tension in framing of diversity applies. We suggest that a critical issue in choosing either positive or negative framings of local policy diversity relates to whether that diversity really is a result of appropriate tailoring to context, or if other factors influence diversity in ways that generate inequity. This research found that much of the diversity can be attributed to an ad hoc combination of whether the people involved work well together or not, are enthusiastic about licensing or not, or creative in their approaches. Better mechanisms are required for cross-fertilisation of ideas and practice among PHTs considering how to engage with alcohol premises licensing.

Some of the most in-depth involvement in licensing occurred in those areas where the responsible person in the PHT was allowed a relatively large percentage of full-time equivalent to proactively engage in the process. This included instances of the PHT being responsible for writing statements of licensing policy or being able to 'walk the beat' with other licensing authorities and bring resultant data from public involvement to bear in representations. These examples were rare, and in the wider ExILEnS study, we found no impact of more intensive PHT engagement in alcohol premises licensing on health or crime outcomes in the short term or over several years.[23] In synthesising all the data from the study, we concluded that this was more likely due to limitations in the power of the licensing system itself rather than a complete lack of impact of PHTs on licensing. We also found clear differences in PHT practice between Scotland and England however, reflecting differences in context and legislation, including the presence of a public health licensing objective only in Scotland, and a requirement to have local licensing fora in Scotland.[5,20]

Strengths and limitations

The main limitations of this study include that the design (structured and in-depth qualitative interviews), in common with earlier research of this nature, does not provide evidence of the effectiveness of involvement in these processes in terms of reducing alcohol-related harms. This is of particular interest for practitioners, as while there is strong, review-level evidence that affecting spatial and temporal alcohol availability is linked to reductions in harm, including some evidence that local authorities that have CIPs or make representations against alcohol licensing applications demonstrate reductions in alcohol-related harms,[24] questions remain as to what PHTs might contribute to such reductions, particularly when such a broad range of approaches have been adop ted.[1,2,19,25,26] This paper is intended to showcase the range of interesting or innovative practices across England and Scotland; it is beyond scope to provide an analysis of differences between the two nations. This is discussed in depth separately, along with a forensic analysis of the two licensing regimes.[5] Another limitation relates to the nature of the data we have collected, as this may not be representative of all local authority contexts, due to geographic patterning. Although we were able to include interviews from site leads for all areas, the exact number of people interviewed for each site varied according to the makeup of the PHT and availability of staff for interview. Efforts were made to follow up with sites after interview to ensure sufficient stakeholder perspectives were gathered to understand the level and complexity of PHT engagement in alcohol licensing. Equally, there is a danger of data loss during participant recall, particularly considering the rate of staff turnover in many local authorities, combined with the longer time frame of the study. However, as an attempt to assess the range of possible approaches, the current study chose to focus on the most active PHTs in licensing, and included cities, towns and rural areas across England and Scotland.

Areas for future research

New statutory licensing guidance in Scotland arguably pushes the systems in England and Scotland further apart, with increasing emphasis on cumulative area-wide effects of alcohol availability in Scottish guidance, notwithstanding the need for each application to be considered on merit.[27] Further research should examine if/how the new guidance may further change PHT practice in Scotland. It would also be important to consider whether there are elements of statutory guidance in Scotland that offer insight into how the same or very similar laws are applied in practice.

We did not analyse the relative impact of different approaches to engaging with licensing (e.g. multiple representations vs. negotiated agreements with applicants). While likely to be valuable for PHTs, this would best be done alongside a detailed assessment of local licensing systems in policy and practice (see below). This would enable assessment of whether specific approaches changed the licensing system as intended, as well as assessment of health and crime outcomes, allowing for modelling complete hypothesised causal pathways.

Conclusion

This is the largest and most geographically diverse study of the different ways that PHTs attempt to influence alcohol availability through licensing in the UK, and the first to do so across both Scotland and England. A range of approaches to engagement in licensing across six

categories of activity are showcased, highlighting local knowledge, resources and expertise. The identified examples will be of value in informing PHT practice in what remains a relatively new area of work for many, despite limitations in the system. The inclusion of examples from both England and Scotland and from a large number of PHTs will facilitate cross-fertilisation of ideas and practice across PHTs. The findings will inform future public health efforts to engage with local licensing and highlight less conventional forms of involvement such as data gathering, working with applicants or getting more directly involved in policy development that merit further attention in research and practice.

Additional information

CRediT contribution statement

All coauthors reviewed and approved the final text of this paper.

Richard Purves (https://orcid.org/0000-0002-6527-0218) (Senior Research Fellow, Institute for Social Marketing and Health, University of Stirling) co-led recruitment, conducted structured and in-depth interviews and contributed to the analysis and interpretation of structured and in-depth interview data. He led on the first and final drafts of the full text, and on revisions.

Andrea Mohan (https://orcid.org/0000-0003-2467-7174) (Lecturer, School of Health Sciences, University of Dundee) contributed to the design of the study. She co-led recruitment, conducted structured and in-depth interviews and led on the analysis of structured interview data. She contributed to the analysis of in-depth interview data. She contributed to the interpretation of all findings and to further drafting and revision of the full text.

Rachel O'Donnell (https://orcid.org/0000-0003-2713-1847) (Research Fellow, Institute for Social Marketing and Health, University of Stirling) supported recruitment for and conducted in-depth interviews and led on the analysis of in-depth interview data. She contributed to the interpretation of all interview data and to drafting and revision of the full text.

Matt Egan (https://orcid.org/0000-0002-4040-200X) (Professor of Public Health, Department of Health Services Research and Policy, London School of Hygiene and Tropical Medicine and Coinvestigator for ExILEnS) contributed to the design of the study and the securing of funding. He supported recruitment, conducted structured interviews and supported analysis of structured interview data. He contributed to the interpretation of all interview data and to drafting and revision of the full text.

Nason Maani (https://orcid.org/0000-0002-3398-0688) (Lecturer in Inequalities and Global Health Policy, School of Social and Political Science, University of Edinburgh) co-led recruitment, conducted structured and in-depth interviews and contributed to the analysis and interpretation of structured and in-depth interview data. He contributed to drafting and revision of the full text.

Niamh Fitzgerald (https://orcid.org/0000-0002-3643-8165) (Professor of Alcohol Policy/Director of the Institute for Social Marketing and Health, University of Stirling and Principal Investigator for ExILEnS) led the design of the study and on securing funding. She supported recruitment, conducted some structured interviews and contributed to analysis and interpretation of all data. She contributed to the conceptualisation of the paper, edited the first full draft of the text and contributed to drafting and revisions of the final text.

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Data-sharing statement

All data requests should be submitted to the corresponding author for consideration. Access to anonymised data may be granted following review.

Ethics statement

The study was approved by the University of Stirling Ethics Committee for NHS, Invasive or Clinical Research in May 2017 (NICR 16/17 – Paper No. 64) and by the London School of Hygiene and Tropical Medicine Ethics Panel in June 2017 (14283). NHS Research and Development approval was secured from all participating NHS Boards in Scotland. This was not required for PHTs in England, which are based within local government.

Information governance statement

The data controller for this study was the University of Stirling. Personal data were limited to contact details for practitioners, which was processed by the University of Stirling and the London School of Hygiene and Tropical Medicine. All data, including recordings and transcripts, were held in confidence, stored securely and destroyed in accordance with the university procedures. All research activity complied with the standards detailed in the Research Governance Framework for Health and Community Care, health and safety regulations, data protection principles, other appropriate statutory legislation and in accordance with Good Clinical Practice.

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List of abbreviations

ADP	Alcohol and Drug Partnership
AFS	Alcohol Focus Scotland
A&E	accident and emergency
CIA	Cumulative Impact Assessment
CIP	Cumulative Impact Policy
CIZ	Cumulative Impact Zone
EXILENS	Exploring the Impact of alcohol premises Licensing in England and Scotland
LSO	licensing standards officer
NIHR	National Institute for Health and Care Research
PHE	Public Health England
PHIAL	Public Health engagement In Alcohol Licensing
PHTs	public health teams
SSC	Study Steering Committee
SLP	Statement of Licensing Policy
TEN	temporary event notice

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Appendix 1

Example 1 – Staff resources

Just one local authority in our sample had created a dedicated post to work full-time on alcohol licensing that was shared with another neighbouring local authority. The post was developed and funded by the local ADP due to a desire to influence alcohol availability and develop a more consistent/streamlined approach to health input to licensing as a statutory consultee. The post was needed in part due to the size of the area and the large volume of alcohol licence applications it received. The role of 'Health Improvement Lead for Alcohol Licensing' was originally created as a secondment opportunity for 12 months but was extended beyond that when the value of the position became clear.

'One of the reasons possibly might have been the fact that [larger area] is a beast in terms of the amount of alcohol licence applications that come in and out of the city. It was a lot of work, and it was deemed that basically something a bit more specialised would have to be created to respond to that efficiently and effectively' (PHT1, Area number withheld due to high risk of deductive disclosure, Scotland).

Developing specialist knowledge and expertise was a key part of the role. The first year in this new post was described as 'really busy', as the post required getting to know '*who the players are in terms of Licensing Standards Officers, the licensing sergeant with the team out at [street name] Police Station and all the other components and get used to the Licensing Board, learn the legal … I did a paralegal course. There was so much going on in that first year and it was really busy*' (PHT1, Area number withheld, Scotland).

However, once the Health Improvement Lead reported that they got up to speed, they felt that there was not enough work to justify a full-time post. This led to the current permanent post being split between two areas. During our follow-up interview, we were able to interview the full-time staff member who had recently taken up the post following the previous incumbent.

'Yes I am the Health Improvement Lead for alcohol licensing and essentially I am the person who triages all the notifications that come into [larger area] in terms of licences and compiles the responses on behalf of [overall area] … Yes so I am 0.6 for [larger area], and 0.4 for [other area]' (PHT2, Area number withheld, Scotland).

Appendix 2

Example 2 – Procedures for TENs

One unusual example of engaging with licensing came from an area in South West England where the local economy was very seasonal and tourist based. Therefore, the PHT, alongside other responsible authorities, committed to additional scrutiny of occasional licences or TENs. Applications for temporary events connected to existing premises were discussed months in advance at responsible authorities' meetings. If these events were due to take place in the summer, the PHT would devote a significant amount of time and resources as early as February to allow them sufficient time to prepare a response.

'*Some of those temporary events are quite substantial events and so they're trying to monitor safety and responsibility and disorder around them*' (PHT, Area 24, England).

The number of applications for temporary events was often so great that events scheduled for summer months would take up 50% of the responsible authorities' meetings in the spring. If events were scheduled to be over a certain capacity, they would be required to apply for their own licence. PHT members would aim to establish operational relationships with the people involved in staging the event. The focus was on providing a safe environment for the event.

'*The new [licensing] committee chair works on welfare in music events and festivals, and so therefore now I've gone from someone who was helpful at the data phase to someone who was really helpful at the operation phase. The chair of the committee and the legal advisor who's in the local authority, both are extremely keen on getting Public Health's voice and evidence accepted in the culture*' (PHT, Area 24, England).

The focus on responsible, safe retail of alcohol was in line with the 'supportive' approach to engagement in alcohol licensing taken by many PHTs in England. Public Health Action in these instances supported the licensing team in their aim of promoting 'safe', 'responsible' retailing of alcohol and/or focused on short-term outcomes other than health, such as crime. This felt more achievable for some PH stakeholders, who often felt that reducing availability was unachievable for licensing committees.

Appendix 3

Example 3 – Combining routine data with local community knowledge – the benefits of a multitier PHT in Scotland

One PHT in the West of Scotland (Area 31) had a team of analysts who compiled data on an annual basis for their area and summarised it for each of the licensing board areas that they covered. This included detailed information on emergency admissions to hospital, deaths, alcohol-related brain disease and mental health discharges. These data were then mapped to intermediate data zones (IDZ) to show which IDZs had relatively high levels of alcohol-related harms across the city. The PHT were able to check the address of any proposed new licence against the data set and pull off the statistics for that area. The analysts spent time with the PHT, helping them understand the data and explaining how it could be useful to them when making representations. The PHT felt that having reliable health data at IDZ level helped them to make decisions on objections and to construct the text of objections; however, the local knowledge of the community-focused PHT representative was considered critical alongside these harder statistics.

'I think that's where Public Health are too, too far removed from what's, I think that's what made some of this work in [area] more successful is the fact that being based in Health Improvement you have more natural connections with people that are working in the communities; whereas Public Health seems to be perhaps a bit more they rely more on the data and the research. And that's not what the Licensing Board wanted to hear. Certainly, they were more interested in that sort of local community facing information' (PHT, Area 31).

Appendix 4

Example 4 – Using bespoke data

In one English area, the PHT realised that the on-trade of the night-time economy was not the sole cause of alcohol-related harm in that area and felt that they needed to take a closer look at off-licences. To do this, they created an alcohol survey to find out what alcohol was available in various off-licence premises. This involved the PHT visiting every premises in the area and recording information (price, volume, product) in relation to products that they deemed high risk (e.g. ciders above 6.5% ABV). This information was used to create a map of the area the PHT could use to illustrate sales of high-risk products and was able to capture changes in the products on offer over time. This information was also used when a national off-licence chain wanted to open a new premises in an area that already experienced high levels of alcohol-related harm due to the sale of high-strength drinks.

'We had a meeting with the applicant who … I mean, we held the meeting with the area manager who was representative of the applicant and during the meeting she sat there and said that she had all of this experience of running licensed premises. There would be a full induction training programme. All of your normal challenge 25, acceptable proof of age, till refusal procedures, company management, alcohol refusal sales report'.

'A number of different types of alcohol would be excluded, but they wouldn't agree to excluding all beers, lagers and ciders with an AVB content above 6.5 per cent, and that was something that from my point of view, public health, was really after, because I knew that in this area [from my data] we had problems with people drinking in homes and the specific drinks that they would be stocking and selling would be this range of drinks that were causing, sort of, real harms. We could see the harms through hospital attendances … and through my survey work' (PHT, Area 38, England).

Appendix 5

Example 5 – Leading the writing of licensing policy

This PHT was a rare example of a PHT who led the rewriting of their licensing policy. In previous years, the SLP was developed without consulting the PHT. When PHT first became part of the licensing regime in 2012, it was felt that the licensing team struggled to understand the role of PH in general (not just in the licensing context). There was also a lack of knowledge and experience in PH about licensing legislation. Taken together, this led to misunderstandings between the departments over what could be achieved, which took some time to work through. This was addressed, in part, through dialogue and offers of training from the PH both to the members of the licensing committee and to the licensing colleagues. Breaking down barriers and building partnership working took time but resulted in a much-improved understanding of how PH could contribute to the licensing process. The team felt that they needed more input into the policy to have an influence on the decision-making process long term. The PHT were asked to lead the drafting of the policy in early 2017. Being involved in writing the licensing policy at such a high level allowed the PHT to include what they felt was best practice in areas such as liaising with applicants and responding to applications.

'I was given the time and the space to do it [write the licensing policy] … it took six, seven months to actually re-write, it was a huge bit of work, and that's what brought about the new licensing policy. So, I suppose that was pivotal … I just went with it and just ploughed stuff in and everything was accepted … which meant I could include health into it, it's got a whole appendix on health, but health was included throughout the whole policy. We included things like child safeguarding within it, which had never been included before, CSE (Child Sexual Exploitation), sexual harassment we included in it, the, and a whole raft of stuff which had never been touched on, which from a public health point of view was wonderful' (PHT, Area 36, England).

A post in the PHT was created specifically to concentrate on licensing with the aim of increasing PH influence in the licensing process through the SLP and to explore if a CIP for certain areas was viable. A CIP would mean that evidence has indicated that the number, type or density of licensed premises in a certain area is impacting adversely on the licensing objectives, namely crime and disorder, public safety, public nuisance and the protection of children from harm. This would mean that any licensing application would be refused unless they could show that there would be no adverse effect on the licensing objectives. A specific post allowed the time and space to grow links with licensing and create trust between the PHT and the licensing department. The process took over 2 years, but eventually the licensing team was happy for the PHT to take the lead in collating the evidence for a CIP, which was agreed by the committee and full council with no challenges or changes. It became apparent the existing policy, which was very basic, would need to be rewritten, and in consultation with the PHT manager, it was agreed that PH would take the lead in a complete rewrite, under the direction of the licensing manager.

The beginning of the rewriting of the policy started before 2017 with a direction from the chair of the Community Safety Partnership to the PH to collate evidence to support a CIP. The evidence (270-page document) was collated with data from the police, the PH and the Community Safety Partnership and sent to the licensing manager, who at the time was not overly supportive of a CIP. However, on presentation of the evidence, they changed their mind, and, when the document was presented to the committee, it was accepted. The CIP was such a radical departure from the existing licensing policy, it was acknowledged that a complete rewrite was required, and after some negotiation, it was agreed the PHT would do it. This was entirely due to the previous work they had completed for the CIP. The licensing manager gave the PHT some very clear directions, and regular meetings were held between the licensing manager and the PHT, which also included legal experts and the PHT manager, who chaired the meetings. Nothing was written without the [licensing] manager's knowledge, and there were several substantial rewrites before all parties were happy. Throughout this time, the PHT had ready access to the licensing manager if needed. The process was reported as 'remarkably smooth' according to the PHT and took about 9 months from start to finish before presentation to the committee. There were no substantial disagreements, and the licensing team was reported to have been very supportive of all the health references and health appendix being put into the policy.

Appendix 6

Example 6 – Working closely with LSOs

Public health teams in Scotland often worked closely with their local LSO. The LSOs were created by the Licensing (Scotland) Act 2005. Each local authority in Scotland must appoint at least one LSO for its area. Their duties include providing interested persons with information and guidance concerning the operation of the licensing act; supervising compliance by licensees with the conditions of their licences and the requirements of the act; and providing mediation services to avoid or resolve disputes between licence holders and any other persons.
In one area in Scotland, where a representative of the local ADP acted as the health lead to the local licensing authorities, they worked very closely with their local LSO. Here, the LSO was heavily involved in the drafting of the SLP and the ADP lead for licensing contributed to the policy through the LSO, working closely together to make recommendations and help to formulate the policy. The ADP and LSO also worked closely in providing training to premises, making presentations to the local licensing forum, and worked on public information campaigns.
This ADP also relied on their close relationship with the LSO when responding to licence applications, which they felt gave several benefits. The LSO met regularly with licensees and possessed in-depth knowledge of premises, which allowed them to advise the ADP whether they should make a representation against new or variation applications. There is no requirement in Scottish law for the PHT (or ADP) to be informed of applications for occasional (one-off licences, similar to TENs in England), but the LSO would flag up any applications they felt would be of concern as explained here:
'Whenever we're notified of an occasional licence that's potentially is going to be questionable by the LSO, *and that's only done through good working relationships with them, we have been able to flag up to other partners that would not necessarily have known anything about licensing but have a role to play. So, people like the Child Protection Committee, our Early Years, Children and Young People's Leadership Group, so they're two different committees that have key stakeholders round the table from various organisations, police health, social work, all with the views of protecting children and young people. So we have been able to flag up to them first of all, this is how licensing impacts on alcohol related harm and availability and this is how you can get involved in terms of … that licensing objective around protecting children and young people from harm … So I think that's been really good because we've been able to raise awareness in those other community groups and strategic groups around licensing and how they can actively play a role'* (PHT, Area 34, Scotland).