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## **“A true partner around the table”? Perceptions of how to strengthen public health’s contributions to the alcohol licensing process**

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### **Abstract**

#### **Introduction:**

There are increased opportunities for public health practitioners in England to shape alcohol availability and reduce harms through a statutory role in licensing processes in local government. However, how public health can effectively influence alcohol licence decision-making is little understood.

#### **Methods:**

A mixed methods study was conducted to identify challenges faced by public health practitioners and mechanisms to strengthen their role. This involved a survey of practitioners across London local authorities (n=18), and four focus group discussions with a range of licensing stakeholders (n= 36).

#### **Results:**

Survey results indicated a varied picture of workload, capacity to respond to licence applications, and levels of influence over decision-making among public health practitioners in London. Practitioners described a felt lack of status within the licence process, and difficulties using and communicating public health evidence effectively, without a health licensing objective. Strategies considered supportive included engaging with other responsible authorities and developing understanding and relationships over time.

#### **Conclusions:**

Against political and resource constraints at local and national government levels, pragmatic approaches for strengthening public health influence over alcohol licensing are required, including

promoting relationships between stakeholders and offering opportunities for public health practitioners to share best practice about making effective contributions to licensing.

## Introduction

Through alcohol licensing, local authorities (LAs) in England can shape alcohol environments in their local area. International evidence demonstrates that regulating the availability and accessibility of alcohol – for example through licensing – can reduce both alcohol consumption [1] and associated health and social harms [2-6]. The recognition in 2011 of a statutory licensing role for health authorities [7] and the 2013 reorganisation of public health into local government [8] in England, provided opportunities for public health to engage directly with the alcohol licensing process and potentially shape local alcohol environments [9, 10]. However, the experiences of public health practitioners (PHPs) trying to influence licensing decision-making through this role remain underexplored. This paper describes results from a mixed methods study of PHPs' contributions to alcohol licensing processes, highlighting perceptions of how to strengthen the public health role.

The Licensing Act 2003 for England and Wales [7] designated a range of LA actors as 'responsible authorities' (RAs) with a right to comment on applications for new licences to sell alcohol, as well as reviews of existing licences. Under the Act, RAs (now including Directors of Public Health) can make 'representations' (objections) to demonstrate if a 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. A representation may recommend restrictions on how or when alcohol can be sold, or recommend refusal or revocation of a licence. If agreement between RAs and licence applicants / holders cannot be reached, the representation(s) are considered at a hearing by the LA's licensing sub-committee, comprising locally elected councillors. They may decide to grant, refuse or revoke a licence, or impose conditions upon the premises and the sale of alcohol.

There are also opportunities for public health to engage with other LA stakeholders to shape local alcohol policy, such as a LA's Statement of Licensing Policy (SLP), or cumulative impact policies designed to restrict new licences or variations in areas of high outlet density [11-15]. Evidence indicates that restricting hours of sale, and policies to reduce the density of outlets are two key alcohol regulation levers at the local level, associated with reductions in alcohol-related hospitalisations [3, 4], road traffic accidents and injury [2], violent and sexual crimes [3], and antisocial behaviour [1, 2].

However, as none of the four licensing objectives explicitly addresses health, PHPs must frame their representations against non-health objectives. The challenges of this have been acknowledged [16, 17], recognising that without a health licensing objective, PHPs face addressing alcohol-related harms through licensing without clear legal authority [14]. A fifth licensing objective – to protect and promote public health – was introduced in Scotland in 2005 and has been debated in England and Wales [10, 18], though currently there is little political support for it [19]. In Scotland, this objective has provided opportunities for public health to influence local alcohol policies [20]. However, recent research has highlighted difficulties operationalising the objective on individual licence applications [20, 21].

It is important to understand more about how PHPs undertake the role of ‘responsible authority’ under current England and Wales legislation, to explore the challenges currently faced by practitioners and to identify the mechanisms – legislative or otherwise – to strengthen their contributions to local alcohol decision-making. By investigating how a (hypothetical) health licensing objective might affect public health’s contribution to licensing work in England, we sought to explore the range of factors that shape PHPs’ influence on alcohol licensing decision-making.

### *Aim*

This paper describes perceptions from a range of stakeholders on how to strengthen the position and practice of public health in alcohol licensing, both with and without changes to current legislation.

## **Methods**

### *Study design and context*

This paper draws from a multi-component study comprising mixed qualitative and quantitative methods, conducted between September 2016 and October 2017, which explored the range of influences on PHPs’ alcohol licensing work across LAs in Greater London. This paper describes findings from a survey and focus group discussions (FGDs) conducted as part of the broader study; for full detail of the methods for all components of the broader study please see *Additional File 1*.

### *Methods and sample – survey*

The survey aimed to capture information about PHPs’ licensing work. Concerted efforts were made to identify the relevant (single) PHP working on alcohol in all 33 Greater London LAs, although this was only possible in 28 LAs. An invitation to participate and a link to an online questionnaire were

sent directly to named contacts in the 28 LAs, with reminders where necessary. The questionnaire took around 15 minutes to complete and included questions on the amount of alcohol licensing work undertaken, the frequency of actions taken on applications, and the resources used to justify representations. Participants were also asked to rate their perceived influence on the outcomes of applications. See *Additional File 2* for the full questionnaire.

#### *Methods and sample - FGDs*

Four FGDs were conducted to explore perceptions of the public health licensing role. Two FGDs were conducted with London PHPs identified through convenience sampling, using existing contacts to invite practitioners involved in alcohol to participate. A third FGD was conducted with a set of RA practitioners at one London LA, selected purposively for their existing engagement as a group. A fourth FGD was conducted with members of a UK network of alcohol licensing stakeholders to capture other perspectives on the public health role.

The FGDs comprised discussion about the role of PH in alcohol licensing and how it can be strengthened, and discussion of three constructed licensing scenarios, including how a (hypothetical) health licensing objective might shape their actions. The discussions were audio recorded and transcribed verbatim, and notes were taken to record non-verbal communication.

#### *Analysis*

The data from the survey were downloaded to Excel for analysis of responses. Results from the survey analysis are presented as descriptive statistics.

The FGD transcripts were uploaded to NVivo 11 software and analysed according to principles of thematic analysis. Initial, inductive, open coding was conducted by two researchers (JR & MM) working on one transcript each to identify broad areas of interest. The initial coding structures were then merged and groups of codes developed through discussion between the coders, before being applied to the subsequent transcripts. Further discussion between the coders supported development of themes relevant to the research question. Final interpretation of the themes and survey data was supported by the other authors.

#### *Ethics*

Approval for this study was granted by the ethics committee of London School of Hygiene & Tropical Medicine (reference 11770). Information about the study was given to all potential participants in advance of the consent process. Written consent was sought from each FGD participant and survey

participants were asked to confirm they understood that completing the questionnaire indicated their consent.

## Results

### *Participants*

From the 28 London LAs in which a named contact for public health licensing work could be found, the questionnaire was completed by PHPs from 18 LAs (18 respondents in total), a response rate of 64% (54% of all London LAs). Across the four FGDs there were a total of 36 participants, and the FGDs lasted between 74 and 114 minutes, with an average of 91 minutes. See *Table i* for a summary of the participants in the survey and FGDs.

### *Key survey results and themes*

The survey responses highlighted a varied picture of PHPs' licensing work (see *Table ii*). The median number of licence applications received by PHPs each month was 10 to 15, and the median number of hours spent per week on licensing by PHPs was 0-2 hours, but two participants reported six hours or more. More than half (10/18) of PHPs stated they occasionally, often or always do not have capacity to act on alcohol licence applications. The survey results complemented key perceptions arising from the FGDs and are synthesised below according to three themes: i) the status of public health in the licensing process; ii) the strengths and weaknesses of the (public health) population perspective; and iii) skills, resources and capacity to contribute. Short quotations from the FGDs are given within the text, and longer quotations are presented in *Table iii*.

#### *i) The status of public health in the licensing process:*

A key perception emerged of public health as a “*poor relation*” in the licensing process, compared with other, more established RAs. PHPs described challenges making representations against licence applications; many felt they cannot “*go it alone*” and their objections only carry weight with the licensing sub-committee if representations are also made by other RAs. This was reflected in the survey: a third of respondents would not make a representation if they knew no other RAs were making representations. 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 receiving applications routinely.

When discussing a (hypothetical) health licensing objective, PHPs asserted that it would raise the “*profile*” of public health in the licensing process. Some felt the objective would increase

understanding of public health perspectives among licensing sub-committee members, helping PHPs to make representations alone. Other RAs in FGD-03, however, were very positive about the current contribution of public health, stating it gives their own representations “*additional strength*”. There were a few accounts of how the position of public health had improved over time; one PHP described developing “*good working relationships*” with other RAs, and now feel they are “*genuine*” partners in the process. Survey results also conveyed perceptions of some level of influence: 13 out of 18 respondents reported they were ‘quite influential’ (although the sample likely reflects public health teams that are more active in alcohol licensing work).

Close working with other RAs, for example by attending regular meetings, co-located working and establishing personal connections, appeared important. Almost all survey respondents (17 / 18) stated that they considered working with other RAs to be ‘important’ for licensing work (*Table ii*), and of the respondents who regularly attend RA meetings (n=8), all felt they were ‘quite influential’ in the licensing process. In contrast, of those who do not have or attend regular RA meetings (n=10), only half felt they were ‘quite influential’. A few FGD participants indicated that a health licensing objective might negatively impact on the “*partnership building*” process between public health and other RAs, if public health were to make representations only against the health objective, engaging less with other RAs.

ii) *Strengths and weaknesses of the population perspective:*

Concerns were articulated over the perceived relevance of public health data for justifying representations, reflecting a common perception that population level data on health harms would not have the geographical specificity expected by licensing sub-committees as it could not be directly linked to individual premises. Practitioners described occasions when their representations had been challenged in hearings, for example by an applicant’s solicitor. As such, some practitioners felt they could only describe the broader “*context*” of alcohol harms, rather than comment on how a specific premises might contribute to these harms.

Some PHPs felt a health licensing objective might enable them to present a more “*holistic argument*” and draw on different sources of data to justify their representations, implying less need to be geographically specific. However, other stakeholders questioned this assumption, stating that a fifth objective would not change the expectation that evidence be “*relevant*” to a premises. There were also different interpretations of whether, under the Licensing Act, representations must draw only

on premises-specific data. One stakeholder stated it is “*impossible*” not to think of a premises within its local context.

There was a clear narrative that the contextual perspective offered by public health can be valuable for “*setting an area-wide agenda*”, contributing to broader policy-making on alcohol licensing, such as the Statement of Licensing Policy (SLP) or cumulative impact policies. A few PHPs described having a “*big role*” in shaping cumulative impact policies, and in FGD-03 there was agreement that the ‘strength’ of the council’s SLP was, in turn, valuable for supporting public health’s representations. In the survey, more respondents prioritised broader alcohol policy-making and strategically positioning public health than acting on individual licences (*Table ii*).

*iii) Skills, resources and capacity:*

While PHPs skills in accessing and analysing different data sources were recognised, their communication of evidence in representations and hearings was not always considered effective. Some PHPs stated they have to work hard to convince licensing sub-committee members of the validity of their data. Other stakeholders suggested that PHPs could make their evidence more “*committee friendly*” and accessible to non-specialists, to avoid undermining their arguments. Many PHPs indicated they would welcome templates for recommending conditions or justifying representations, and stated that they would like opportunities to learn “*best practice*” from one another.

The capacity for licensing work among PHPs was also identified as a concern. From the survey, the reported hours per week, number of applications and capacity to take action was varied across the sample (see *Table ii*). In the FGDs, some participants implied that the licensing workload sometimes meant they were forced to prioritise certain types of application (for example reviews) or only give responses when specifically asked by other RAs. Staffing cuts and turnover within public health teams was also identified as threatening the “*institutional knowledge*” required to understand the licensing process, and the survey indicated a majority of respondents (11 / 18) had been doing licensing work for twelve months or less.

Some PHPs indicated a health licensing objective might “*compel*” LAs to allocate more resources to support public health’s licensing work, including investing in health data sources. However, there were also fears that the objective would mean a greater imperative for public health to act on applications, which might require “*a lot more work*” of PHPs.

## **Discussion**



*Main findings of this study:*

This paper described perceptions of the role of public health in alcohol licensing and how to strengthen it, from a range of stakeholders working (predominantly) in local authorities in London. From a survey and four FGDs, results indicate weaknesses in the current public health position and influence over alcohol licensing decisions. These include a felt lack of status and recognition of the value of public health compared with other RAs; challenges faced by PHPs in applying area-level data to individual licence applications; weaknesses in communicating evidence to other stakeholders; and a lack of resources to support full engagement in the licensing process.

Perceptions of how to strengthen the public health contribution focused both on legislation, in the form of a health licensing objective, and on other, non-legislative measures. PHPs envisaged a health objective helping improve recognition of the public health contribution, lending 'authority' to their role [14]. They also felt it might lead to increased resourcing to support this public health function within LAs, and enable the use of different sources of data, including population-level data, to support representations. However, limitations of a health licensing objective was also recognised, by PH practitioners and other stakeholders, including not removing the need for data to be relevant (if not specific) to individual premises, and even undermining partnership working with other RAs if public health focus only on the health objective.

Other mechanisms identified for strengthening the public health contribution included fostering engagement between public health and other RAs (eg through regular meetings or co-located working), to support representations and share public health perspectives. This was considered valuable for influencing broader licensing policy, and in turn, for supporting PHPs' own representations. PHPs also requested opportunities to share best licensing practice across the profession and mechanisms to retain 'institutional knowledge' of the licensing process within changing public health teams. Finally, other stakeholders recommended development of PHPs' skills in communicating their evidence effectively to non-specialist audiences (eg licensing sub-committee members).

*What is already known on this topic:*

It is well-evidenced that mechanisms to limit the availability and accessibility of alcohol are among the most effective for reducing alcohol-related health harms at the population level [2, 5, 6, 12]. However, the uncertainty of the public health position in alcohol licensing within LAs in England has also been recognised, given the lack of legal licensing objective relating to health [14]. In Scotland, the addition of a health licensing objective has influenced local statements of alcohol policy [20], but

challenges remain around how public health can act effectively on individual licences [21]. Currently, there appears little political appetite for establishing a fifth, health licensing objective in England [18], and with continuing cuts to local government budgets [22], resources to support public health licensing work remain limited, and in competition with other public health priorities [23].

*What this study adds:*

This study adds understanding of the challenges and opportunities faced by PHPs involved in alcohol licensing in London, from a range of perspectives, with insights that are potentially relevant beyond the London context. It demonstrates varied capacity and perceived levels of success among PHPs to influence licensing, felt (by some) to relate to the absence of a health licensing objective. It also highlights the range of mechanisms that might be employed to strengthen public health contributions to alcohol licensing without legislative change, including: increasing engagement with other RAs, contributing to broader licensing policy within LAs, improving communication of evidence to non-specialist audiences, and promoting opportunities for shared learning among PHPs.

*Limitations of this study:*

This study focused predominantly on experiences of PHPs from LAs in Greater London, which potentially limits generalisation of the results to other types of LA across England and Wales. However, insights are potentially transferable to other settings due to the similarity of licensing structures across LAs, and due to the variety of London boroughs reflected in the sample, in terms of demographics, size of night time economy, and council politics. The survey sample was too small to enable tests of statistical significance, and was likely biased towards public health teams more active in alcohol licensing work. However, the difficulties faced in identifying the PHPs doing alcohol licensing work in some LAs suggest that there are widespread challenges faced in resourcing *any* alcohol licensing work in some public health teams. This indicates even more powerfully the need for actions to strengthen this work.

*Conclusions:*

This study has made recommendations for strengthening public health contributions to licensing work that reflect current political and resources constraints: increase engagement between public health and other RAs; contribute to broader licensing policy within LAs; improve communication of evidence in representations; and identify opportunities for shared learning among PHPs. Further research is needed, however, to consider the most effective allocation of public health time and resources to licensing work alongside other programmes for reducing alcohol harms.

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*Table i* Summary of sampling and participants for survey and focus group discussions (FGDs)

<b>Population sampled</b>		<b>Total no.</b>	<b>Responses / Participants</b>
			<i>Type of participant</i>
<b>Survey</b>	33 London LAs approached, questionnaire sent to named contacts at 28 LAs	<b>18 responses</b>	PH practitioner: 16 <sup>1</sup>
<b>Focus Group Discussions</b>		<b>36 participants</b>	
FGD 1	PH practitioners across London LAs	6	PH practitioner: 6
FGD 2	PH practitioners across London LAs	8	PH practitioner: 8
FGD 3	Responsible authority practitioners in one London LA	8	PH practitioner: 1 Licensing practitioner: 2 Legal officer: 1 Environmental health practitioner: 2 Police officer: 1 Trading standards officer: 1
FGD 4	Members of a national licensing network	14	National / regional government agency: 6 Charity / third sector organisation: 3 Professional organisation: 3 Academic researcher: 1

<sup>1</sup> Two practitioners each worked across two LAs so completed the questionnaire twice, once for each LA.

Table ii: Summary of responses to relevant survey questions (n=18)

Survey question	Responses (n=18)				
	0-5	6-10	10-15	16-20	21+
<i>On average, how many alcohol licence applications do you receive per month?</i>	4	5	6	2	1
	<b>0-2 hours</b>	<b>3-5 hours</b>	<b>6-8 hours</b>	<b>9+ hours</b>	
<i>On average, how much time is spent on alcohol licensing work by public health?</i>	10	6	1	1	
	<b>0 - 6 months</b>	<b>7-12 months</b>	<b>&gt; 12 months</b>		
<i>How long have you been doing alcohol licensing work in a public health capacity?</i>	4	7	7		
	<b>Yes</b>	<b>No</b>	<b>Don't know</b>		
<i>Are there formal responsible authority meetings in your LA?</i>	10	6	2		
<i>Do you regularly attend responsible authority meetings?</i>	8	10	0		
<i>What influences your decision not to take action on an application?</i>					
Screened as low priority	12	6	0		
Not supported by the SLP	9	9	0		
Unlikely to be supported by committee	8	10	0		
Lack of data to support the representation	8	10	0		
No other RAs making a representation	6	12	0		
Lack of time or capacity	3	15	0		
	<b>Always</b>	<b>Often</b>	<b>Occasionally</b>	<b>Never</b>	<b>No response</b>
<i>How often do you feel you don't have time/capacity to take act on applications?</i>	1	2	7	8	0

	<b>Very important</b>	<b>Quite important</b>	<b>Not very important</b>	<b>Not important</b>	<b>No response</b>
<i>What priorities do you consider to be important in public health licensing work?</i>					
Contributing and influencing local alcohol policies and strategies	16	2	0	0	0
Working in partnership with other RAs	16	1	1	0	0
Increasing understanding of PH perspectives and values	14	2	1	0	1
Making a representation that is upheld at the sub-committee	8	6	4	0	0
Negotiating conditions with applicant before sub-committee	5	9	2	1	1
	<b>Very influential</b>	<b>Quite influential</b>	<b>Not very influential</b>	<b>Not at all influential</b>	<b>No response</b>
<i>How influential do you feel public health is in shaping alcohol licensing work?</i>					
	0	13	4	1	0

Table iii: Key themes and illustrative quotations from the focus group discussions

	Key themes from FGD data	Illustrative quotation	Respondent(s)
	Perceptions of PH as a lesser partner in the licensing process	<i>"...if we ask public health why don't they sort of, you know, take the initiative a bit more... one of the first things they say is, well we're often told when we get to the hearing with the representation we're told, why weren't the police interested, you know, if the police aren't bothered about it is it really a problem? And ... they feel unwelcome, they don't feel like they're a true partner around the table."</i>	Stakeholder, FGD 04
<b>The status of public health as an RA</b>	How a health licensing objective would improve the status of public health and their representations	<i><b>P1:</b> It is hard to demonstrate what do we do apart from just really core, basic activities. So I guess from that point of view it [a health licensing objective] would help with some of that wider understanding of where [public health] is meant to sit across the local authority.</i>  <i><b>P2:</b> And I think it raises our profile as well. Because with the [licensing sub-committee] members, and you're dealing with them, and see what you can do and what you present, I mean it can be beneficial if we have an objective."</i>	PHPs, FGD 01
	Finding ways to engage with other RAs to strengthen the PH position	<i>"... it's finding that person in the team that you can have consistent dialogue with. So there's one person that we'll talk to all the time about every single licensing application. And then there's others that we talk for review or variation, and there's others that you talk to if there's a little bit more information that's required and that will talk to you in turn when they require data and a little bit more information."</i>	PHP, FGD 02
<b>Strengths and weaknesses of the population perspective</b>	Being challenged on the geographic specificity of public health data	<i>"And it's about the specificity of the data ... And I can say this because I got roasted ... Even though at the end of the day our representation was taken... the licence denied, but I got roasted for lack of specificity, lack of being specific."</i>	PHP, FGD 01
	The value of the population perspective for supporting other representations	<i><b>P1:</b> ...it's very helpful to have somebody from a health perspective to flag up and strengthen and support it in relation to the harm caused by those products and the health and wider society perspective.</i>  <i><b>P2:</b> Very much so, I think that's, that gives us some additional strength"</i>	Responsible Authority practitioners, FGD 03



	Value of contextual perspective and population or area-level data for shaping broader licensing policies	<i>"... 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."</i>	Stakeholder, FGD 04
	Need to strengthen PHPs' communication of evidence to others	<i>"... [public health] people are even less used to dealing with councillors, even less used to kind of dealing with anybody who haven't necessarily got that understanding of the evidence that they used to."</i>	Stakeholder, FGD 04
<b>Skills, resources and capacity</b>	Lack of capacity forces some practitioners to prioritise how they respond to applications	<i>"...they tell me when there's an application that I should be interested in rather than me look at everything that comes in because it's just not going to happen."</i>	PHP, FGD 01
	Public health licensing objective might increase imperative to act on licence applications and require more resources	<i>"We would have that confidence but on, like you said, that's likely to mean more work or have to have that strong leadership thing, so that screening process really has to be robust... I think it would be nice to know whether the Directors of Public Health would agree to provide more resources if we did have, because I'm slightly panicking now cos I'm thinking it's a really great idea... And just suddenly it's kinda hit me actually how much work, actual work would be needed if we did have [it]! [Laughter]"</i>	PHP, FGD 02

## **Additional File 1 – Description of Methods for Full Study**

### **Overall Study Aim:**

This study aimed to explore the range of factors, processes and structures that influence the nature of public health practitioners' contributions to alcohol licensing processes within the context of local authority settings in London, and to identify mechanisms for strengthening these contributions.

### **Study Design and Methodology:**

A mixed methods, multi-component study design was selected, drawing on several different methodological approaches to achieve the study aim. The study was conducted between September 2016 and October 2017, with predominant focus on public health practice in local authorities in Greater London, UK.

Mixed methods were selected to explore different dimensions of public health contributions to alcohol licensing processes, and to explore perceptions of how these contributions can be strengthened. Each method was chosen to meet a different research question, but the data and analysis were synthesised to facilitate interpretations to address the overall aim. Our study design and use of mixed methods was not for purposes of triangulation – to check and assure the validity of the results of the study by comparison between methods – but more for 'developmental' and 'expansion' purposes (Hesse-Biber, 2010). Some methods were employed to help the development and refinement of other methods, conducted later in the study; for example the ethnographic observation in several local authorities helped guide the development of questions and shape the focus of the survey of public health practitioners across all Greater London local authorities. The combination of methods, with different guiding research questions and assumptions about what kinds of knowledge can be produced, also enabled a broad, but detailed, understanding of the different facets of, and influences on, public health contributions to alcohol licensing processes, interpreted within the context of local authorities. These methods are described below and summarised in *Table 1*.

#### *a) Ethnographic observation of public health practice*

Drawing on research using 'organisational ethnography' (Ybema, Yanow, Wels, & Kamsteeg, 2009) to explore the dynamics and dimensions of health and social policy and decision-making in local and

national government contexts (Phillips & Green, 2015; Qureshi, 2013; Stevens, 2011), we chose an ethnographic approach to understand the reality of public health alcohol licensing work in context. This approach involved spending extended amounts of time observing the practice of public health (PH) practitioners as they undertook alcohol licensing work, reflecting an assumption of ethnography that by being 'embedded' (Lewis & Russell, 2011) in the context of interest, more in depth understanding of processes, relationships and structures can be generated. The ethnographic approach included shadowing practitioners as they screened licensing applications and wrote representations; asking them about their work; observing meetings relating to licensing attended by PH practitioners; and observing licensing sub-committee hearings at which public health made a representation.

Data were collected through observation notes (taken in brief during fieldwork sessions, and written up in full afterwards), and supplemented with reflexive field notes (usually recorded after fieldwork sessions), to reflect on how understanding was being generated through the fieldwork.

#### *b) Survey on public health practitioners' licensing work*

A survey was conducted via an online questionnaire, using BOS online survey tool, to capture an overview of public health practitioners' approaches to, and experiences of alcohol licensing work across LAs in Greater London. The questions for the questionnaire were developed using insights from the first phase of ethnographic observation (in two LAs). The questionnaire was piloted with two PH practitioners to check for comprehension and relevance, and the questions were then refined. The questionnaire comprised 18 questions (some with several sub-questions), and were a mixture of multiple choice, rating and open text questions. It took around 15 minutes to complete.

Questions ranged from asking PH practitioners about their typical alcohol licensing workload (for example average number of applications per month, number of person-hours spent on licensing work per week); about different types of actions taken on licensing applications and the frequency of these (for example how often they submit a representation or negotiate with applicants); about relationships with other responsible authorities (RAs) (for example whether and how often they attend meetings with other RAs); to questions about what is important in public health alcohol licensing work, and perceived influence of it.

#### *c) Focus group discussions*

Focus group discussions (FGDs) were conducted with a range of stakeholders associated with the alcohol licensing process to explore perceptions of the role of public health in licensing, and how to strengthen PH contributions, including through a (hypothetical) fifth, health-focused licensing

objective. FGDs were selected to enable discussion from a range of perspectives and also to explore dynamics between practitioners from different professions (in FGD-03), in a simulation of the relationships between different RAs within one local authority. The structure of the FGDs comprised first a more open discussion of the role and position of public health in alcohol licensing, perceived strengths and weaknesses of their contribution, and perceptions of how a health-focused licensing objective might affect this role. The second part of the FGDs comprised discussion focused around three licensing scenarios – brief descriptions of (hypothetical) licensing applications, which were constructed drawing on insights from the ethnographic data collection. Participants were asked to read the scenarios, identify what actions might be considered to promote or protect public health, and discuss what might be done if there were a health-focused licensing objective.

All FGDs were audio recorded and transcribed verbatim. Notes were also taken by a researcher (in addition to the facilitator) during the discussions to capture non-verbal communications, and to enable identification of voices on the audio file.

#### *d) Semi-structured interviews*

Interviews were conducted with a range of stakeholders to explore different perceptions of the role of public health in alcohol licensing, and to generate understanding of the challenges and opportunities to promote and protect public health through licensing from a range of perspectives. Participants were identified to reflect a variety of responsible authority professions, including public health, as well as other licensing stakeholders, such as a solicitor with legal experience of the alcohol licensing process and a councillor with experience of the licensing sub-committee in one LA. The interviews were also conducted as a mechanism to try to engage with LAs across London that had not already been represented in other parts of the study, particularly those with less public health licensing capacity.

The interview topic guide comprised a series of semi-structured questions that were tailored to the specific background of the participant. The questions explored the participant's professional role and experience with alcohol licensing, perceptions of the public health role, experiences of engaging with public health for licensing (if not a PH practitioner), and perceptions of strengths and weaknesses of the public health contribution. Interviews were audio recorded and transcribed verbatim.

#### *e) Routine data analysis*

The data routinely recorded by public health practitioners as part of the alcohol licensing process were identified as a valuable resource for identifying and quantifying the types of actions taken by

public health in relation to different types of licence application, and the subsequent outcomes of actions taken. This routine data were collated for a 9 month period across a sample of LAs in London, and key data extracted included:

- Number and type of licence applications received
- Types of premises and whether in a cumulative impact zone / special policy area
- Types of actions taken (eg no action, informal negotiation, formal representation)
- Outcomes of actions taken and of licence application (supplemented where necessary by information extracted from the local authority licensing database, publically available online).

## **Sampling and Recruitment**

The 33 local authorities across Greater London (including City of London Corporation) comprised the overall study sample, but with different sampling strategies and samples recruited for each of the study components, described below.

### *a) Ethnographic observation*

Eight LAs were recruited, via a purposive and convenience sampling approach, to be included in the ethnographic observations of public health practice in the alcohol licensing approach. These eight included five inner London and three outer London boroughs, and all had some level of public health involvement in alcohol licensing, identified through existing contacts in each LA. Ethnographic observations occurred as per the specific schedule of activities and licensing workload of the practitioners, over a period of between four and twelve weeks. In four of the LAs, observations typically occurred once or twice a week (usually for around 2 hours at a time) over a period of eight to ten weeks. In two LAs, where the workload of licensing applications was much smaller, ethnographic observations were more sporadic, occurring as and when practitioners had applications to screen, or were attending a hearing or responsible authority (RA) meeting, over a period of around twelve weeks (approximately 5 separate observations in each LA in total). For the final two LAs, several observations were made in a shorter period of time (around four weeks), reflecting the time constraints of the practitioners involved.

Observations of public health practitioners' work were conducted in relation to alcohol licensing, which involved situated conversations and observations of particular tasks such as screening

applications, scanning data sources, liaising with other responsible authorities, writing representations and presenting statements at licensing sub-committee hearings.

*b) Survey on public health practitioners' licensing work*

The survey sought to sample all 33 LAs in London by identifying a named person in the public health team at each LA was responsible for alcohol licensing (or alcohol work in general, if no licensing work was being done) , and to invite them to participate. Where contacts were already known, the survey was explained to the practitioner via email, phone or during a face to face meeting and if the practitioner agreed to take part, the link to the online questionnaire was emailed to them. Where no contact was already known, a number of methods were used to try and identify the appropriate person. This included looking on council webpages, particularly licensing pages, for names of public health contacts; calling or emailing the public health team asking to speak to the alcohol lead, and contacting the licensing department in the LA to ask who the public health licensing contact is.

Out of 33 LAs a named public health contact responsible for alcohol licensing work was identified in 28 boroughs. Of the 28 boroughs where a named contact was identified, 18 completed survey and 10 did not, despite several follow-up prompts. In three of the LAs where a named contact was not identified, someone in the public health department was spoken to but they explained that the department did not really do much or any work on alcohol or licensing and could not name anyone who would be willing to complete the questionnaire. In one LA, it was not possible to get through to the public health department despite trying to call through the main council switchboard and emailing both a generic public health email address and the Director of Public Health, and the licensing department did not have a contact for anyone in public health. In the final LA, the public health department was joint between two boroughs. A named contact was identified for one of the boroughs but they, and another PH practitioner I spoke to in the department, did not know who was responsible for the other borough. Several attempts were made to get through to licensing in this LA but there was continually no answer.

It is likely that those practitioners who could be contacted and participated in the survey reflect LAs in London with a public health department that is more actively engaged in the alcohol licensing process than those LAs who did not complete the survey or for whom a named contact in the public health team could not be identified.

*c) Focus group discussions*

Four FGDs were conducted; two with public health practitioners from across London LAs, one with a group of responsible authority practitioners from one LA, and one with a group of stakeholders from

a nationwide network of stakeholders interested in alcohol licensing. Sampling was purposive and convenient, drawing on existing networks of contacts generated through other parts of the study (ethnographic observations and survey). For FGDs 1 and 2, 14 public health practitioners in total participated, reflecting 13 different LAs. For FGD 3, one LA was selected purposively for its established connections between public health and other responsible authorities. Eight practitioners participated in the FGD, which followed a regular meeting between the RAs. Participants included practitioners from public health, environmental health, licensing, police, trading standards and the council legal department. FGD 4 took place following a regular meeting of a national licensing stakeholder group, and 14 people participated, reflecting local and national government, the health sector, academia and third sector and non-for-profit organisations.

*d) Semi-structured interviews*

Stakeholders from a range of local authority professions were recruited to participate in semi-structured interviews using a purposive approach, particularly to explore perspectives and contexts that were not strongly reflected in other parts of the study. Potential participants were identified using existing networks of contacts across London LAs. Three participants were alcohol leads or senior public health practitioners from local authorities which were not represented in the ethnographic observations or focus group studies. Five participants were drawn from other RAs, including licensing, trading standards, police and regulatory services management. One participant was a legal expert with experience of supporting alcohol licensing in local government (though outside London) and the final participant was a councillor and licensing sub-committee chair from one London LA.

Table 1 Summary of study methods, aims and samples

Study component	Aim	Data collection period	Sample population
Ethnographic observation	To understand processes and practices of public health alcohol licensing work in context	September '16 – May '17	8 LAs (5 inner London, 3 outer London); between 6 and 25 hours spent in each LA.
Survey	To capture information about PH practitioners' alcohol licensing work	March – May '17	(All) 33 London LAs approached; named contacts identified and questionnaire sent to 28 LAs; 18 responses received.
Focus group discussions	To explore perceptions of how to strengthen PH contributions to licensing	June – July '17	2 FGDs of PH practitioners (total = 14); 1 FGD of responsible authority representatives from one LA (n = 8); 1 FGD of members of a national licensing stakeholder group (n = 14).
Semi-structured interviews	To explore perceptions of PH role in alcohol licensing, from a range of perspectives	May – October '17	10 participants reflecting range of stakeholders (PH alcohol leads, other responsible authorities, legal experts, councillors).
Routine data analysis	To summarise actions taken by PH practitioners on alcohol licence applications and outcomes	January – October '17	Data from 5 LAs (all inner London) for 9 month period.

## Data Analysis

### a) Qualitative data

Qualitative data (including ethnographic fieldnotes, observation notes, interview transcripts, focus group discussion transcripts) were uploaded to NVivo 11 program to enable to the organisation and management of the different types of data. An inductive, bottom-up coding framework was identified through preliminary thematic coding of a sample of transcripts and notes, and then applied to the remainder of the data sources, revising and expanding the coding framework in an iterative manner. In addition to the formal coding of data, reflexive memos were recorded to capture emerging themes, constructs and questions, and used to develop further the analytical 'narrative' across the data following coding.



## *b) Quantitative data*

Questionnaire responses were downloaded to Excel and simple descriptive statistics and counts were conducted, with comparisons conducted between respondents for certain questions (for example comparing inner and outer London boroughs, and LAs with and without regular RA meetings). The routine public health licensing data were extracted from the original databases, cleaned and then subjected to descriptive statistics and counts in Excel.

## **Ethical Procedures**

The study received ethical approval from the LSHTM Research Ethics Committee in September 2017 (reference 11770). Consent for each component of the study was sought separately. For the ethnographic observations, consent was sought from the Director of Public Health (or equivalent senior public health lead) at each LA, followed by individual written consent from each practitioner whose work was being observed. At internal (closed) meetings, consent to observe the meeting and take notes was sought from all meeting attendees. Consent was not sought for observation of licensing sub-committee hearings as these are public events. For the focus group discussions and interviews, individual written consent was taken prior to participation, and for the survey, participants were asked to confirm at the beginning of the online questionnaire that they consented to their responses being included in the study. Permission to extract and use the routine licensing data was sought from the relevant public health practitioners.

For all parts of the study, names, specific job titles, local authorities and place names were anonymised to assure confidentiality, and any identifying details in transcripts have been removed or revised.

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