Public Health England

Protecting and improving the nation's health

Findings from the pilot of the analytical support package for alcohol licensing

A resource to support the role of public health teams in alcohol licensing

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Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. We do this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. We are an executive agency of the Department of Health, and are a distinct delivery organisation with operational autonomy to advise and support government, local authorities and the NHS in a professionally independent manner.

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Executive summary

Introduction

Public Health England (PHE) works to support local public health teams in their role as a responsible authority, providing guidance, workshops and training. In 2016, with the support of the Home Office and Department of Health, PHE developed and piloted an analytical support package (ASP) to help public health teams in their existing role as a responsible authority as defined in the Licensing Act, and to explore the data and processes that would support a theoretical public health licensing objective.

A team based in Sunderland and Bristol universities was commissioned to lead the evaluation of the pilot. This report, based on their findings, explores the experience of pilot areas using the ASP tool. It describes how they accessed relevant health information and how that information was presented in fulfilling their role as a responsible authority.

The pilot areas also explored how ASP-generated data and evidence could be of use in the context of a theoretical fifth licensing objective addressing the protection of public health.

This report presents the findings from the project and how the areas engaged with the package in attempting to improve public health's engagement with alcohol licensing.

Method

Eight pilot sites were selected across England, the pilot areas were supplied with a guidance document setting out time scales, reporting and evaluation methods. The ASP itself consisted of a data library, a local health tool to map health data at a local level and guidance on how to collate relevant information from primary data via surveys.

A series of baseline interviews and focus groups were conducted with responsible authority representatives from the participating areas. These included the police, fire service, health and safety, trading standards, planning, environmental health, child protection and senior public health representation (either the DPH or the local authority lead for alcohol).

Findings

- the ASP was seen as a useful resource that should, with further development, be made available nationally
- local public health teams need access to analytical capacity in order to maximise the most of the ASP
- the level of access to health data varied, as did the granularity of the available data. In particular, a number of areas had difficulties in accessing Hospital Episode Statistics (HES) data
- despite barriers to data access, there was a recognition of the importance and potential for a wider range of health information and data to be explored and used
- where health data is used it should be part of a wider 'story' about meeting the licensing objectives.

The participants' experience was that an over-reliance on data limited their effectiveness in contributing to licensing decisions. Training and support for public health teams on using the tool and how to present information could help improve effectiveness.

- public health teams need to be clear on the objectives of engaging with alcohol licensing and what success looks like.

Strong partnership structures and working relationships with other responsible authorities to demonstrate the impact on health harms were seen to be important.

- some pilot areas identified more scope within the current objectives and provided examples of the positive role public health can play in providing effective engagement within the current licensing framework
- responses highlighted a mixed view on public health's role and there wasn't a clear consensus on the reach of public health within the current Licensing Act.

This had an impact on the openness to engagement, acceptability of data within licensing and influenced the responses that came out of the work.

- the absence of a public health licensing objective was seen to be a barrier to public health being effective

The conclusions

Overall the ASP was seen as a useful addition to the resources that public health can call on in carrying out the role of a responsible authority. The ability for areas to adapt and enhance the supplied datasets, with locally collected data and/or bespoke local mapping information, helped areas think creatively and practically about how to access and utilise a range of available health information in ways applicable to local licensing practices.

The work highlights ongoing challenges and areas of improvement which can be framed under three domains.

Operational: The capacity of public health teams to engage in alcohol licensing work and the analytical capacity to work with and access data.

Skills: The ability of public health teams to present health data in a format and context that licensing committees can assimilate in their decision making process. The ability of those in licensing to understand and make the best use of public health's contribution to promoting the licensing objectives.

Custom and practice: The existing custom and practice (relationships between responsible authorities, definitions of roles and interpretation of guidance and information) in a local area was an important factor in the level of engagement and effectiveness of public health in engaging with alcohol licensing.

The areas that experimented with the mock hearing or who presented their evidence to workshops provided examples of how local areas could establish evidence relevant to decisions based on a public health licensing objective but also highlighted challenges in doing so.

This project suggests that if a public health licensing objective is to be considered the wording of the objective and supporting guidance around it will be key. Alternatively, consideration could be given to strengthen guidance around the current objectives and recommended local practices to enhance and reinforce the role that public health plays.

Next steps

Based on the findings of the report, PHE has developed the ASP into a nationally available resource. In line with PHE's digital first strategy, this will be a web based resource which we will continue to update with information and case studies.

While designed for public health teams, the ASP is accessible to all responsible authorities: https://www.gov.uk/guidance/alcohol-licensing-a-guide-for-public-health-teams

We hope the information included in this report proves useful to public health teams working in licensing and their partners in developing effective engagement in licensing.

Introduction and background

The Licensing Act and public health

The Licensing Act 2003[1], came into force in 2005. It introduced a modern, integrated licensing scheme, administered by local authorities covering the sale by retail of alcohol, the supply of alcohol, the provision of various forms of entertainment and the provision of late night refreshment.

The focus of the 2003 Act is the promotion of the four statutory objectives which must be addressed when any licensing functions are undertaken. The licensing objectives are:

- the prevention of crime and disorder
- public safety
- the prevention of public nuisance
- the protection of children from harm

Under the Act a number of public bodies, known as responsible authorities, must be notified of applications and are entitled to make representations to the licensing authority and seek reviews of licences where appropriate.

Since 2012 health bodies, directors of public health (DPH) in England and local health boards (LHBs) in Wales have been included as responsible authorities.

PHE has been working to support local public health teams in their role as a responsible authority, providing guidance, workshops and training. In addition, PHE hosts the National Public Health and Licensing Network which brings together public health, licensing, police, academic and voluntary sector actors.

While there are examples of effective public health engagement in alcohol licensing, it is inconsistent and varies by region with some public health teams still struggling to successfully embed themselves in the process. Such inconsistency is not unique to public health involvement but applies equally to other responsible authorities despite a longer bedding-in period.

[1] http://www.legislation.gov.uk/ukpga/2003/17/contents

Local alcohol action areas

In 2014 the Home Office launched the first round of the local alcohol action areas (LAAA) programme[2], which included 12 local authorities in England that explored how evidence from health data could be used by public health bodies to reduce health harms and play a more effective role in licensing.

Findings from the work demonstrated some promising approaches to accessing, gathering and sharing health data to establish robust evidence bases in support of licensing decisions.

However, the work clearly identified barriers which would need to be overcome, in order to support and expand the role of public health in licensing, in particular:

- public health teams needed more support and training to optimise their role in the current licensing framework
- ensuring better access to all types of health data
- improving data-sharing agreements
- ensuring sufficient analytical resource at a local level

Based on findings it was recommended that a tool needed to be developed that would enable public health teams to have better access to health data, along with the ability to map and present data to address some of these barriers.

PHE, with support from the Home Office and Department of Health, agreed to develop and test an ASP. The ASP was developed to help public health teams in their existing role as a ‘responsible authority’.

In addition, the pilot areas were asked to consider how their experience of using the ASP might support local authorities in establishing evidence relevant to decisions that could be based on a licensing objective related to public health, if this were introduced in the future.

[2] https://www.gov.uk/government/publications/local-alcohol-action-areas

Methodology

In December 2015, PHE identified a long list of 15 potential pilot sites based on suggestions from PHE regional centre colleagues, the National Public Health and Licensing Network and requests from local areas.

In January 2016, a panel made up of PHE, Home Office, Department of Health, the Local Government Association (LGA) and Alcohol Research UK shortlisted nine local authorities based on geographical spread, urban and rural location and capacity to engage in the project. Of the nine authorities invited to be part of the programme, eight chose to become involved. This fell to seven after one was unable to continue with the project for internal reasons.

The project ran for four months from February to June 2016. Each area was provided with the ASP, along with an overview of the project including timescales, expectations and governance structures. The selected areas were provided with data for two additional alcohol indicators: alcohol-related mortality and alcohol-related hospital admissions - narrow measure. Both indicators were provided with five-year standardised ratios at middle layer super output areas (MSOA) and local authority levels.

Governance and oversight of the project was provided by PHE's national reducing alcohol harm team, with support from the Home Office, LGA and Alcohol Research UK. The National Public Health and Licensing Network served as an expert working group to provide feedback and advice to local areas. In addition, legal support was provided by a licensing barrister contracted by PHE.

Pilot areas were supported by PHE centre leads who provided the main contact point for the duration of the project. Local authority areas were expected to establish their own local governance and support structures for this work.

PHE commissioned a research team from Sunderland and Bristol universities to evaluate the pilot project based on the following objectives:

- to describe the strengths and weaknesses of the ASP as deployed in the pilot areas
- to determine the validity of the data produced and its applicability for supporting licensing decisions, including on health grounds
- to determine the extent to which public health engagement and data deployment is currently constrained by the lack of a public health licensing objective
- to determine the extent to which public health engagement and data deployment is currently constrained by the lack of a public health licensing objective

The pilot evaluation team worked directly with the pilot sites and provided feedback to PHE's national team.

This was a qualitative study and data was collected using both one-to-one interviews and focus groups. Participants were sometimes under time constraints and in some cases were unable to stay for the full session or the number of questions was reduced.

A small number of participants who had attended the focus groups had no knowledge of the ASP and could not recall if they had been consulted about the ASP. This may have been due to the researcher requesting as many as possible responsible authorities to attend the focus groups and prior to this the participants were not directly involved in the pilot study. The eight focus groups involved local public health and licensing teams across the pilot areas and consisted of a total of 31 participants with group size ranging from two to eight.

People with a range of roles participated in the focus groups, including public health intelligence analysts, police, community safety officers, trading standards, environmental health, licensing officers, fire officers, enforcement officers and one health improvement manager. There were no representatives from child protection.

Information was collected using four distinct methods:

- five baseline interviews (with at least two informants)
- three mock 'licensing hearing' type scenarios (in three slightly different formats)
- two shared learning events (after one month and then at the project's conclusion)
- focus groups (involving a total of 31 participants across eight sites)

The baseline interviews established what mechanisms were in place before implementing the ASP in each pilot area. As part of the evaluation, pilot areas were encouraged where possible to undertake mock scenarios using completed licensing hearings, reviews from the past, or using scenarios based on fictitious but typical applications. Findings and reflections from mock scenarios have been included in the results section. Two shared learning events were organised to exchange experiences and share solutions at the mid-term of the project (April) and at the end (September).

In addition, the national PHE lead for the project presented the ASP at a meeting of the West Midlands Alcohol Licensing Network and received feedback which was passed on to the evaluation team.

Limitation of the project

Levels of engagement between local licensing teams, responsible authorities and local public health teams vary widely across the country. Pilot authorities were not randomly selected, so the existing relationships between public health and licensing in these locations may have been more developed than in some others. However, previous LAAA areas were excluded in order to ensure pilot areas had not established processes that were beyond what would be expected in a randomly selected authority.

The pilots were short and the evaluation was carried out within a tight timeframe. We were, therefore, able to provide a process evaluation which tested some aspects of the ASP more thoroughly than others. The evaluation is unable to predict what the specific effects of the ASP would be on licensing practice in non-participating areas. As would be expected in a full roll-out, participating areas took different approaches to testing the ASP.

The analytical support package

The purpose of the ASP was to address issues identified in the 2014 LAAA programme, and found in particular the need to:

- improve understanding around the evidential requirements for licensing decisions based on health grounds
- create mechanisms for improving local data access and analysis
- develop better partnership working across public health and other agencies involved in alcohol licensing
- develop skills and capacity within public health teams for working in the licensing context

Designed as a 'one-stop shop' resource, the ASP included a collection of nationally available data and materials public health teams could use according to their assessment of what would be productive. The main components of the ASP are:

- an alcohol harms and licensing data library: provides a list of relevant datasets and information sources organised by licensing objective. For each entry it identifies where data is available and at what geographical granularity
- specific signposting and support in accessing and using databases and mapping tools including PHE's Local Health tool. This provides access to interactive maps and reports at both middle layer super output areas (MSOA) and local authority levels
- guidance on how to collate information collected from primary data (eg via local surveys) to support engagement in the licensing process. This section also includes guidance on how to set up information-sharing agreements to access data that is available but not yet accessed by responsible authorities

It was recognised that some pilot areas might already have data tools resources they could use alongside the ASP, or want to create their own bespoke tools.

For the purposes of the pilot the ASP contained nationally available data sources at a level all areas could access. It was anticipated that the quality, regularity and availability of a number of the datasets listed within the ASP would vary depending on local practice, with some areas having access to data at a lower geographical level than was contained in the ASP.

How it was developed

In developing the ASP, PHE reviewed existing resources for relevance to the project:

- the library tool drew on existing work in London
- an initial prototype of the alcohol harms and data library had been tested as part of the LAAA programme, and had proved popular (this was updated, following feedback)

PHE's Risk Factors Intelligence (RFI) team reviewed two existing PHE web-based resources, Local Health[3] and Shape[4], to establish their capability for use in licensing: Local Health was identified as the most compatible as it allowed areas to include their own data on the site and was therefore highlighted in the ASP.

Local Health provides access to interactive maps and reports at a middle super output area (MSOA) and at local authority level. Reports produced in Local Health allow for the comparison of any selected area to the England average for a range of indicators.

Shape is a web-enabled, evidence-based application which informs and supports the strategic planning of services and physical assets across a whole health economy.

The ASP flagged other national data bases such as police.uk[5] and LG Inform[6] along with information on how to use GIS mapping software.

Guidance on how to collate information collected from primary data (eg via local surveys) to support engagement in the licensing process was based on the work of Middlesbrough Council. This was reviewed and updated by PHE's RFI team.

Feedback on the prototype ASP was collected from members of the National Public Health and Licensing Network and reviewed by a barrister before it was provided to the pilot areas.

[3] http://www.localhealth.org.uk
[4] https://shape.phe.org.uk/
[5] https://www.police.uk/
[6] http://lginform.local.gov.uk/

Level of engagement prior to pilot

Public health teams had varying degrees of engagement with alcohol licensing before the start of the pilot. Those areas with a strong engagement in licensing had developed working relationships with other responsible authorities and been involved in the drafting of local statements of licensing policy. They had also provided data for cumulative impact policies and put in representations on specific applications. Other areas had limited engagement, either through officers in the public health team having recently taken over the role or due to capacity and workload issues. They acknowledged that they wanted to do more and saw this project as an opportunity to do so.

The focus on what areas wanted to achieve through their involvement in the project also varied. Some hoped to use the pilot to develop their processes for engaging in licensing, others to explore what more could be done within the Act, while others wanted to explore a public health licensing objective to support their work around devolution.

“The problem that we’ve got at the moment with public health is that the licensing regime has been inaccessible, nationally, to public health teams because of the way the thing is being presented. So the purpose of this [project] was to say how we can make best use of what we’ve already got. And … If we find that we still are struggling, and then let’s talk about changing the Act.” (Council Solicitor)

These different levels of engagement and focus are reflected in the findings contained within the report.

Findings

Usefulness of the ASP

Overall, participants welcomed the support package, particularly as a straightforward one-stop resource with links to many data sources. They felt it was useful to have information in one place with the flexibility to add locally tailored data.

The support package had the greatest value in those areas where participants had been able to make their own adaptations and enhance the supplied datasets with either locally collected data or bespoke local mapping information.

While there was a sound appreciation of the potential benefits that better access to localised health information could offer the licensing process, concerns were raised around the potential for public health becoming too reliant on the ASP or too over-confident of their data.

“I think the other danger of the analytical toolkit is that it gives Public Health false confidence… We’re good data handlers… But in a very direct correlation, kind of way…” (Public Health)

Some areas hadn’t fully explored all the elements of the ASP by the end of the pilot and were planning to continue developing their use after the pilot finished. Even within the short time frame, however, all areas were able to make some practical use of the ASP either to identify and analyse data, developing mapping tools, or create ways of better presenting available data to colleagues.

“... we built a web service with the mapping system built into it. And then within that you can place (information) of any kind at different geographies. You know, it can work areas up to wards, up to districts, then it does thematic maps. You can put point level data on there as well.” (Analyst)

The most widely used component in the ASP appeared to be the data library. Most of the pilot areas spent time reviewing the data library to establish the range of data they could access and to identify what was missing. However, this was time-consuming and had clear capacity implications.

Some areas developed tools that pulled together data from the support package and allowed users to search for geographically specific health indicators based on the postcode of premises.

Areas that were able to put time into using the ASP reported that, while it took time initially to review the information and develop maps, doing so helped with their licensing work in the long run.

It was felt that the tool could be improved by making it more user-friendly, with a user guide that included case studies on how areas used the elements of the tool as well as practice tips on how to present the data. A section on issues such as the economic costs of local alcohol harms (for example, costs of an assault on A&E or the cost of an ambulance callout) was also requested.

There were different views on the scope and usage of the ASP after the pilot ended. The more positive view was that ASP, or the tools that had been created by the pilot, could be used more widely than just supporting licensing decisions. Within licensing it could be used to help strengthen the voice of other responsible authorities such as the Local Safeguarding Children Board by making it easier to access and present their own data. Outside of licensing, some believed the tool could support public health's commissioning function. Another view held by a minority was that the ASP would have limited use until a public health licensing objective was introduced.

"The data will also be really relevant to someone like LSCB [Local Safeguarding Children Board] where, at the moment, their input has been quite generic because they haven't necessarily been pointed in the direction of saying, 'How about you try this?' So LSCB so far, in the last ten years, I don't think have ever talked about, non-school attendance. Whereas this gives us an 'in' to that. It might actually make LSCB's voice louder." (Analyst)

Case study: Gateshead

The public health team in Gateshead were already strongly engaged with licensing colleagues and their work was valued by partners. They were a member of the area's Responsible Authorities Group and built on the good practice identified by Middlesbrough in making best use of legislative frameworks.

They had confidence in exploring creative uses of existing licensing legislation and drew on the experience of developing a hot food takeaway supplementary planning document as well as producing health harm ward profiles for the revised Statement of Licensing Policy (January 2016) .

When it came to their involvement in the ASP pilot the licensing committee, legal team and key elected members supported public health involvement in the pilot. The team examined licensable activities in the ward areas, looking especially at the types of licensing activities, when they took place and whether the licence holders were complying with licence conditions. The team liaised with other responsible

authorities potential licence reviews and the DPH used the available data to make representations on two licence applications.

The ASP was used to identify areas of concern within the borough. The Gateshead team developed their own tool allowing them to search using the postcode of premises, with data on the ward the premises was in also showing up. The tool ranked the ward against a continuum from poor to good health outcomes comparing the ward with the Gateshead and national averages.

Using GIS mapping software, the team were able to produce a range of maps with Gateshead and ward boundaries that included all the licensed premises mapped against a range of relevant health data.

Experience of accessing the information

The level of access to, and granularity of, health data varied between areas, with accessing HES[7] data cited as the area in need of most improvement. As with the earlier LAAA programme, it wasn't unusual to find that while one local area had full access to a dataset others did not. While there were barriers, there was also recognition of the importance of accessing such data and the potential for a wider range of information/data being available that hadn't been looked at or explored by local areas.

Usually, areas had access to health data as a consequence of locally developed solutions. In particular, shared analytical posts or information-sharing agreements. For example, in one area GP practices provided information on a range of data directly to the public health team on a quarterly basis. Other information arrangements came about based on contacts within organisations. Capacity and resource management affected how much information was accessed through, and created from, the ASP. This was especially the case where staff without data training were involved.

"It's just with, obviously, our capacity and the analytical capacity – I'm just a one-man show at the moment. So, it would be helpful to get the toolkit user-friendly for people without a data background. To be able to take the key facts they need to bring a representation forward. I think that would definitely be helpful." (Public Health)

The most useful elements of the available data resource were local health data links, where both standardised hospital admission rates for alcohol-related harm and standardised mortality rates for alcohol-related conditions were accessible by middle super output area (MSOA).

[7] http://content.digital.nhs.uk/hes

A number of pilot areas stated that they had strong links with local health networks such as hospitals, GPs and third sector organisations. There were, however, some issues with primary care data sharing in particular, which hindered the process of timely access to relevant health data:

“There are big issues in how [data has] been coded with people being admitted to A&E with alcohol-related admissions. With them using different ways of assessing individuals when they come in and not necessarily admitting them but putting them in a, kind of, holding loop while they assess them.” (Analyst)

In some areas, however, data-sharing practices with hospitals were working effectively:

“Well, we have pretty strong agreements in place with health colleagues and our providers, in terms of users and hospital admissions, so they’re being aggregated into LSOAs and suppressed wherever they’re too small and then applying a thematic range to show them.” (Analyst)

Local authority level data, such as is provided by Local Alcohol Profiles for England[8] (LAPE) or treatment access information from the National Drug Treatment Monitoring System[9] (NDTMS) were useful for background context and in making the case to local councillors about the relative priority that their authority should attach to alcohol harms. This was particularly useful in areas with relatively high levels of harm.

Two promising approaches were identified during the 2014 LAAA programme: Middlesbrough ran a localised survey within treatment services asking service users about their drinking behaviours, consumption levels and purchasing habits; and Stoke-on-Trent surveyed 2,000 adult residents about alcohol purchases in the previous week.

As part of the ASP pilot project Gateshead and County Durham developed a similar questionnaire for individuals entering alcohol treatment and Wigan used information from a questionnaire carried out with treatment service users in July 2015 which included information on where, and at what times, alcohol was purchased.

Another approach that was being looked at (but hadn’t been fully explored) was how to capture the voice of the community and young people, including their experiences of alcohol harm linked to licensed premises. Some areas also explored talking to different services within the council or voluntary sector to gather local intelligence.

“[We have used a] young person’s trading standards survey and we’ve done some local amplification of that with our big user ‘Our youth.’ (Licensing Officer)

[8] http://www.lape.org.uk/
[9] https://www.ndtms.net

“We’ve initially worked internally with our drugs and alcohol lead. We’ve also been in touch with voluntary sectors [group] that run some of our services and awareness. And they also deal with street drinking so they have a lot of intelligence and knowledge locally in terms of how we can apply that to appropriate premises and licences. So they’ve been doing work around the street drinking. We’ve been able to use that, so it sounds more robust in terms of appealing to the committee than some of the health data.” (Public Health)

There was an acknowledgment that more information was available which hadn’t been looked at or explored locally. Areas were already starting to identify data gaps and think about potential other avenues for other more local data such as housing, suicide audits and NHS health checks. In reviewing their data, one area noted that road traffic crashes [RTCs] had high numbers of casualties who were under the influence of alcohol which included intoxicated pedestrians who had staggered into the road in areas with high numbers of late-night licensed premises.

A majority of the areas identified a clear gap around accessing data on supermarkets, off licenses and online alcohol sales.

“So say, for example, all those people who live in X are actually buying all of their alcohol from Y. Ok? We can’t restrict that. We can restrict in X, but we can’t restrict in Y where everyone is getting it from. So Y is like ‘happy days – let’s bring on another 24-hour supermarket’. Because we’ve not shown any link between X and Y... because we don’t know it.” *(*Trading Standards)

Even within the short timescales of the project several pilot areas had been able to use the data and develop relatively advanced protocols for dealing with the information including their own data repositories and mapping tools to support their licensing work.

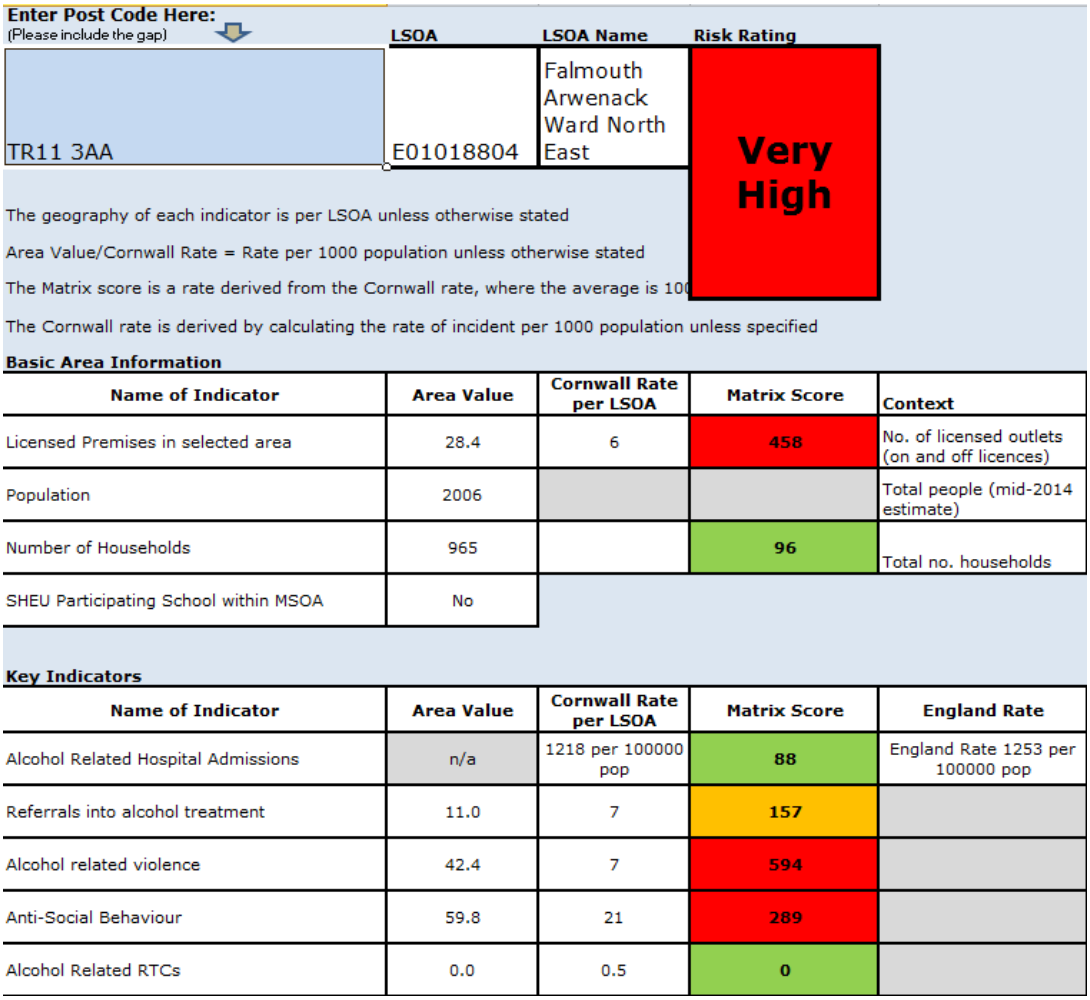
Case study: Cornwall

Cornwall’s public health team used the ASP project to identify local gaps in data and develop a ‘mapping priority areas’ tool based around five key indicators:

- alcohol-related hospital admissions
- referrals into alcohol treatment
- alcohol-related violence
- ASB/street drinking
- alcohol-related road traffic collisions

These were presented alongside a range of supporting data including: noise complaints, hospital stays for alcohol harm, alcohol-related morbidity, domestic abuse and other alcohol-related crime.

The tool allows the user to identify the level of health harm at a postcode level in comparison with the average rate for the county.



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LSOA	LSOA Name	Risk Rating
TR11 3AA	E01018804	Falmouth Arwenack Ward North East	Very High

The geography of each indicator is per LSOA unless otherwise stated

Area Value/Cornwall Rate = Rate per 1000 population unless otherwise stated

The Matrix score is a rate derived from the Cornwall rate, where the average is 10

The Cornwall rate is derived by calculating the rate of incident per 1000 population unless specified

Basic Area Information

Name of Indicator	Area Value	Cornwall Rate per LSOA	Matrix Score	Context
Licensed Premises in selected area	28.4	6	458	No. of licensed outlets (on and off licences)
Population	2006			Total people (mid-2014 estimate)
Number of Households	965		96	Total no. households
SHEU Participating School within MSOA	No			

Key Indicators

Name of Indicator	Area Value	Cornwall Rate per LSOA	Matrix Score	England Rate
Alcohol Related Hospital Admissions	n/a	1218 per 100000 pop	88	England Rate 1253 per 100000 pop
Referrals into alcohol treatment	11.0	7	157	
Alcohol related violence	42.4	7	594	
Anti-Social Behaviour	59.8	21	289	
Alcohol Related RTCs	0.0	0.5	0	

“Once we had raw numbers for each LSOA, we put those into a matrix based on an average per 1,000 people of population for that area. We worked out an average for each indicator, where 100 was the actual average - which is how the alcohol-related hospital admissions data was presented to us in the first place. We married up the best of our data using that same principle, so that where we had 100 as an average for Cornwall, or England, in the case of the hospital admissions, then we could compare all the indicators on a like-for-like basis. Using a bit of conditional formatting in Excel, we came up with a ranking system where anything particularly high would come up as red. Adding then our five indicators together, we could then come up with an average risk for any particular area. We came up with the top 25, which are our most risky areas.” (Analyst)

Barriers to accessing useful data

While a wide range of data was accessed at varying levels, issues around access, granularity and usability were identified. Having access to the right kind of data was seen as critical, but there was frustration when data was inaccessible.

“This kind of empirical data - it’s the stuff that sends lawyers howling down the corridor, saying to their clients: ‘You better start giving in now, because you’re not going to get this.’ But if we haven’t got that information it puts us in a very weak bargaining position.” (Licensing Authority)

Earlier work as part of the LAAA programme had already identified access to localised hospital admissions as a problem for public health teams. This was addressed in the ASP by the inclusion of a section on NHS Digital’s new hospital activity data extract service[10], which provides local authorities with direct access to inpatient, outpatient and A&E data, updated on a monthly basis, for the whole of England for the last ten years (seven in the case of A&E).

Nevertheless, while the data is available to local authority public health teams there were still some problems accessing hospital episode statistics (HES). This was often cited as the area in need of most improvement. Accessing local HES data from the national extract was, for some, frustrated by the large file sizes and the amount of time analysts would need to spend cleaning the data. One pilot area reported experiencing significant time delays in obtaining the national data sharing agreement, though several others found local data sharing arrangements or shared posts allowed them to bypass such obstacles.

“Data itself [is] quite tricky to come by in an awful lot of instances [with] people being reluctant to share for various reasons. We’re still waiting on some areas, especially around hospital episode statistics.” (Analyst)

Access issues were not limited to HES: assault data collected from A&E departments and ambulance data were also identified. Pilot areas reported engaging these services in an attempt to access data, but finding it challenging especially given the short time scales of the ASP project.

In addition, participants acknowledged that while data from sources like LAPE or NDTMS could be useful as part of the background context it had limited relevance to representations about specific, individual premises.

[10] http://content.digital.nhs.uk/hesextract

“And a lot of them (ie data sources) were the level I could use for background setting etc., but when we're really trying to drill down to areas to look at individual premises or groups of premises, it probably wasn't always going to be that useful.” (Analyst)

A&E and Ambulance Service data were, at times, criticised for poor coding recording of information. For example, there were issues in getting the location of pick up, or the initial assault, which limited the ability of responsible authorities to use the information in a licensing context.

“I’m sure that doctors and nurses in hospitals and paramedics from the ambulance service are rushed off their feet, but it’s something that could be put in place as a standard line of questioning: Where were you? Where have you been? That would enable health to feed back into the equation, and when they go to hearings actually be able to say, ‘Look, we can show from our evidence that this particular premises is responsible for x, y and z.’” (Public Health)

However, the criticisms on accessing data were not universal; some areas (with good analytical capacity and information-sharing agreements) felt that they had access to a wide range of data at the right geographical level to be used in licensing.

Experience of presenting the data

Public health as a responsible authority

The definition of the role of public health as a responsible authority varied across areas.

The Home Office guidance on Section 182 of the Licensing Act provides a clear outline of the role of public health in promoting the objectives of the Act. The guidance provides details of how public health links to all four of the licensing objectives. Guidance jointly published by PHE and the LGA builds on the Home Office guidance and makes the case for positive engagement, setting out the possible scope of public health involvement.

The Home Office guidance[11] says:

“Health bodies may hold information which other responsible authorities do not, but which would assist a licensing authority in exercising its functions. This information may be used by the health body to make representations in its own right or to support representations by other responsible authorities, such as the police. Such representations can potentially be made on the grounds of all four licensing objectives.”

PHE and the LGA are also clear in the guidance[12] published in 2014:

“The role of the DPH is to help promote the health and wellbeing of the local populations they serve. This is an expansive remit that influences a wide range of circumstances, including local licensing arrangements. Similarly the licensing regime is concerned with the promotion of the licensing objectives, which collectively seek to protect the quality of life for those who live, and work in the vicinity of licensed premises and those who socialise in licensed premises. This focus on the wellbeing of the wider community via licensing is an important addition to public health teams’ existing work to promote the wellbeing in their localities.”

However, local context, custom and practice, and resource issues are as likely to determine the level of engagement that public health teams have in licensing decisions as guidance from central government. In addition we see examples that suggest that public health’s role in promoting the licensing objectives is not always well understood. At times this can lead to misunderstanding about the outcomes public health should be

[11] Revised Guidance issued under section 182 of the Licensing Act 2003 (Home Office, 2015)
[12] Public health and the Licensing Act 2003 – guidance note on effective participation by public health teams (PHE and LGA, 2014)

seeking, their ability to make representations on their own and the objectives their data can be linked to.

“I have been slated in licensing hearings [by applicant’s solicitors] for talking about public safety; for misunderstanding what public safety actually means. Because we looked at illicit and smuggled alcohol, I dared to suggest that public safety would actually encompass things like alcohol that had no markings on it. That was, unsafe, basically. Our licensing committee disagreed with the solicitor when [the solicitor] said that I was wrong and that I shouldn’t be mentioning public safety in my rep at all.” (Public Health*)*

The experiences of those involved in this pilot reflect this, and there were different views on the reach of public health in making representations on licensing applications. This had an impact on the perceived acceptability of health data within the process and influenced the responses that came out of the pilot.

Possibly due to the pilots focus on testing how public health teams could gather and use health data at a low geography level, interview responses focused predominantly on the impact of that data on individual premises representations.

The main difference of opinion on individual premises representations was on whether the Act requires premises specific data or licensing committees could take into account area based data in forming a view on applications. While some argued representations had to use premises specific data, others in the pilot were able to demonstrate that it was possible to use health data at an area-based level in representations; and had sought legal opinion and other related evidence to back this up.

There was wider agreement that, in the context of the local authority’s work on licensing, public health data could be used effectively in the mediation and engagement with applications, development of cumulative impact policies (CIPS) and the preparation of Statements of Licensing Policy.

There was also acknowledgement from some respondents that some of the licensing objectives were under-used and that public health could have more input in, for example, the child protection objective.

“The child protection provision is hugely under-used and much more could be made of it, especially with off-licence locations and normalisation of the ‘corner-shop off-sales combined with sweet-shop’ phenomenon.” (Licensing officer)

Presenting data in context

Participants recognised that collecting and analysing data was only one part of the process; the way the information was presented was as, if not more, important to it being available.

The ASP, while helping participants to find and access data, wasn't designed to resolve the need for information to be presented in context and in a format that was understood by Councillors, legal advisors and other responsible authorities. Nonetheless, the pilot provides some learning in this area.

Public health and others involved in the pilot suggested that public health needed to present a stronger narrative, which includes data but builds a picture and explains the context of the area in which a decision is required and how that ties to the promotion of the licensing objectives.

“The actual processes and the infrastructure - it’s not just a case of sharing data, it’s really what you do with it. You know, how you pull that together to actually present something that is fit for purpose legally; how are we going to present this or that? The terminology and the robustness of information (is critical) because things can get thrown out of court just for one little word in the wrong place.” (Public health)

The experience that public health teams brought to presenting information played a key role into how effective they were. Many public health participants saw themselves as inexperienced in licensing, particularly in understanding the legal process and presenting in front of the committee. There was a fear of going up against an experienced lawyer for an applicant without training in how to deal with their style of questioning. There was acknowledgement of the need for public health colleagues to be trained in both applying and presenting data well.

“I think if you’re going to use health you should make sure that the person who is going to do it actually has some training around the basics of licensing as a basic principle.” (Community safety)

Training wasn’t just seen as an issue for public health teams; participants discussed the need to support the council’s legal officers and committee members in their familiarity with the data and arguments of public health teams.

Wigan found training their committee (including council legal services and the officers that support the committee) useful. They hired a barrister to provide training to all members and responsible authorities. This led to an increased understanding of the role public health could play in alcohol licensing and clarity for public health officers.

Another participating area felt that working with the committee and other responsible authorities on the pilot had helped build a better understanding of and acceptance of public health's role in licensing from all involved.

“I think it would be maybe training beyond the responsible authority; extending to licensing committees and people who are on those panels. Because I think, in terms of supporting them in their decision-making, they really have to understand the process”. (Public health)

Established processes made it easier for effective, targeted engagement for public health teams with limited capacity.

“So we know what our issues are locally in the borough and we knew what conditions we wanted to put on licences. In terms of moving forward, our involvement in actual applications ... wasn’t probably as productive or strong as it could be. That’s mainly down to capacity issues” (Public health)

Working in partnership with other responsible authorities has helped public health to make relevant and effective representations. Examples of partnership working included: public health taking part in visits to licensed premises; attending bi-monthly licensing meetings and developing joint representations on applications with other responsible authorities.

One public health team described their role as providing an extra pair of eyes for the other responsible authorities and another talked about how public health had become the business of all of the responsible authorities.

Similarly other responsible authorities reported that working with public health colleagues provided them with opportunities to access advice and shared learning.

“Doing that partnership over the last number of years, my licensing officers have now got public health in their heads. When they are talking to new licensees, new applications, they’ll already have that in their heads, in that we know our public health. It’s part of the culture.” (Police)

“Although it’s not an objective at the minute, we’ll include public health on those visits and they’ll come out and speak to the person and say, ‘Right, well, advertising-wise we’d rather you had it here, than here. How much space are you actually putting over to alcohol within the off licence?’ for instance. ‘Right, well, we think it should be this much.’” (Police)

Case study: Wigan

Getting legal advice and formulating the argument

Before the start of their pilot Wigan had already developed a data tool for all lower super output areas (LSOAs), which they updated to include health data as part of the pilot. The tool highlights any problems or issues an area may have at LSOA level, which can be shown on heat maps of the neighbourhood.

The local authority commissioned independent legal advice from a barrister on the use of the tool and area-based health data and the likelihood of it being used successfully as part of a representation to a licensing committee. This advice confirmed that there is 'nothing which prohibits a locality-based representation[s]'. This is in keeping with the Court of Appeal Judgment in the case of 'Hope & Glory' which stated that licensing decisions 'involve an evaluation of what is to be regarded as reasonably acceptable in the particular location.' This means that decisions from individual premises are taken and made in the context of the locality.

The barrister's advice was that, while Wigan's tool demonstrated the levels of alcohol-related disruption within a geographical area, it did not show the impact an extension of opening hours, or the opening of further premises, would have.

Additional supporting evidence would be needed that showed that increased opening hours or an increase in density of establishments is statistically likely to result in more problems. Without supporting information the barrister felt the "decision [was] open to challenge on the basis that the LA has given undue weight to its own extrapolation and opinion, without a proper evidential base".

Following the barristers advice officers developed a directory of supporting evidence from credible sources, in which supporting evidence is captured under each of the licensing objectives.

Case study: Leeds

Public health in Leeds have been actively engaging in licensing for the last three years and assisted in the development of local licensing guidance for South Leeds. The guidance aims to assist licence applications in two post code areas of the city and contains a range of information and support on how applicants can reduce negative impacts.

The guidance encourages applicants to consider in their operating schedule:

- the layout of the local area and physical environment including crime and disorder hotspots, proximity to residential premises and proximity to areas where children and young persons may congregate
- any risk posed to the local area by the proposed licensable activities
- any local initiatives which may help mitigate potential risks.

For their first representation and to test out the robustness of public health data the public health tea asked for conditions on an application including; no alcohol to be sold from 2am onwards, instead of 24 hours a licence of 2am with no single cans and no bottles of cider under one litre and no beer or cider over 6.5%. The conditions were accepted by the premises owner and the health data was seen as a contributing factor for the outcome of that application.

Examples of implementation

Even with the mixed views, public health teams with more experience of the process have been (and continue to be) able to demonstrate their impact across a range of activity including negotiations with licensees, contributing to representations, representations being upheld at magistrates courts, presenting at licensing committee meetings, contributing to CIPs, and supporting development of local Statements of Licensing Policy).

The following are just some of the examples provided by areas of their involvement in licensing. More examples of public health engagement can be found on the knowledge hub forum ‘using health data in licensing’ and within the Institute of Licensing Journal which has a public health feature.

- under the public safety objective, the local public health team supported the review of a pub selling illicit vodka by providing a detailed report on the harmful impacts of drinking industrial strength alcohol to trading standards, who led the representation
- public health evidence was influential in a hearing based on the grounds of the protection of children from harm. The data was included in a report which went to the pub company, on the basis of which the employee involved in supplying to underage customers was sacked
- using street drinking evidence and intelligence from their anti-social behaviour team, one public health team negotiated conditions including a requirement that alcohol not be displayed in the shop front of a premises that was opening up across the road from a rehabilitation centre, which had clients involved in street drinking

Areas of effective engagement.

When reviewing the information provided by those involved in the pilot on effective engagement in licensing, four key areas for effective engagement came out from the work and are summarised below.

Knowledge	• having a clear understanding of the role of a responsible authority and what this means for public health • the importance of knowing the local licensing policies, case law and the Section 182 Guidance and how to apply it • the extent and scope of the objectives • working with the committee and other responsible authorities to share knowledge and understanding of public health and licensing • sharing knowledge with other responsible authorities about when public health are likely to get involved in making a representation
Context	• understanding the context in which evidence is being presented to the committee, and how the data will be received • the importance of narrative and making sure councillors understand what public health is presenting. • understanding the context in which the data is being used for, eg CIPs, Statement of Licensing policy, review or representation.
Processes	• developing a clear process for responding to applications
Partnership	• having effective partnerships with other responsible authorities - understanding how public health can contribute to needs of other responsible authorities. • partnership with the Council's legal teams and licensing committee • being an active part in responsible authority groups or active lines of communication

Health as a licensing objective

A recent survey by the Local Government Association confirmed that many public health officials would like to see public health included as a fifth licensing objective.[13] This finding was replicated among the public health teams involved in this pilot.

“If you want to use this [health] information then we need to have [health as a licensing objective] there, to legitimise our position. Otherwise we will always just be a voice in the background and supporting, which has its place, and that’s absolutely great - but why make us a responsible authority?” (Public Health)

The focus of the project had been on the exploration of the data and how it could be effectively used within current and future legislation and not on the wording of an objective. While all of the pilot areas were asked for, and expressed, views on establishing health as a licensing objective four areas chose to explore the issues in more detail by running exercises in which public health was used to challenge a hypothetical application based on differing views and wording of a health objective. Two authorities (Gateshead and County Durham) jointly ran a full mock licensing hearing; Cornwall ran a workshop with relevant licensing colleagues; and Wigan presented representations using a hypothetical public health objective to the Chair of Licensing and the Council solicitors.

Each of the areas developed a different definition of, and wording for, a health objective

Gateshead and County Durham had an undefined public health objective. In the mock hearings there was some ambiguity as to whether the representation was attempting to address concerns under the current licensing objectives or was instead aimed at health as a fifth licensing objective.

Cornwall made use of postcode-level health data to bring representations based on the current objectives and asked participants to consider what difference a health objective would make. Opinion in the workshops were split on the need for an additional objective and the added value above and beyond what is already covered within the scope of the current objectives.

Wigan developed their own defined wellbeing and public health objective and created a briefing document for everyone involved outlining the definition of the objective. For each of the applications presented the Chair of Licensing and the council solicitor found it easy to envisage how the applications could be refused based on the evidence presented.

[13] LGA Survey: Public Health and the Licensing Process (Local Government Association, 2016)

Case study: County Durham and Gateshead

County Durham and Gateshead combined their efforts and worked collaboratively to run a full mock licensing hearing. In the mock hearing, public health submitted a representation against a 'new' hypothetical off-licence application on the basis of a broad public health objective as well as under objectives for crime and disorder and the protection of children from harm.

Public health was the only responsible authority to make a representation, which was based on underage sales from the surrounding off-licences.

"…it was in a deprived area, known to have issues with alcohol and underage sales. As there is no CIP in County Durham, we were unable to use off-licence density as a reason for rejecting the application." (Public Health)

Information (in the form of maps and charts) to support the representation, including treatment data, was presented with the help of the licensing mapping tool, LAPE and NHS data that was available at MSOA and LSOA levels.

Preparations also took into account a diverse range of variables, such as:

- the unit price of alcohol available in the area:
- the local Statement of Licensing Policy
  (good practice conditions that might be relevant)
- proposed hours of business
- under-18 alcohol-related hospital admissions in the area
- test purchase operations recently carried out in the area

The case study provided valuable insights into some of the issues public health face in presenting their data, especially the need to present information to committees in an accessible way.

While sympathetic to the issues public health raised, the licensing committee members felt the narrative needed to be backed up with relevant supporting evidence and wider information to develop their case. Subsequent interviews also highlighted that there was some confusion over the licensing objective against which the representation was being made.

"The mock hearing was supposed to be just using the health objective; however, I think the details of this objective and how it would be used were unclear, so many reverted to thinking of it as an 'add-on' to the current objectives. Public Health data is also difficult to communicate to those who do not have much knowledge of public health." (Public Health).

Even in the context of the mock hearing, the committee thought that public health should not be the only responsible authority presenting information, particularly when it came to presenting information under what were perceived to be the domains of other responsible authorities. Not having other responsible authorities supporting public health in the representation was felt to lessen the impact.

“The Council was unclear as to why we presented police data, as the police did not put in a representation; however, the police purposely did not put in a representation, as they wanted 'health' to stand on its own. The Council seemed to value the police representation/opinion more than that of public health.” (Public Health)

In this case the representation was unsuccessful and the hypothetical application was granted, as the committee felt the information presented by public health wasn’t strong enough on its own to refuse an application. Those involved struggled to conceptualise what a public health objective would look like.

The people involved in the mock hearing felt that key to supporting this was training to develop presentation skills for representations suited to the format of review hearings. This was particularly the case for public health teams, but also for other responsible authorities. There was also an acknowledgement that the training needs went both ways: council officials and other responsible authorities needed to become more conversant with public health evidence, as well as needing support in presenting their own evidence more effectively. The lack of experience presenting to the licensing committee was seen as a considerable barrier in making the case.

“There’s almost a naivety that outside of the appeal hearing I can sit and ask trading standard’s opinion, or licensing’s opinion, or the solicitor’s opinion, and then I get into the hearing and I realise that I can’t. You know, there is no-one with whom we could have a meaningful exchange. That’s just an experience thing: that’s not necessarily a training thing. But that’s been a big learning curve.” (Public Health)

Case study: A wellbeing and public health objective in Wigan

The public health team presented two cases in which a pub and an off-licence wanted to extend their opening hours. The representations were made to the Chair of Licensing and the committee’s legal advisors, using a hypothetical wellbeing and public health objective and the existing crime and disorder objective. A template for presenting cases was developed which included the data, legal opinion and references to appropriate evidence of locality based harms.

Guidance was developed (broadly in line with the existing Section 182 guidance) for the chair and legal advisors to use when reviewing the case.

Health information was generated using data links from the ASP that were included within the mapping tool. The tool was used to highlight problems or issues in the area in which the application was made and data at LSOA level was identified and set out in a colour coded chart which highlighted the severity and/or number of incidences for a range of measures.

This was supported with relevant information from the 'index of evidence' including a directory of quotes from credible sources suggesting that more premises or longer opening hours are likely to be detrimental to the community and individuals.

"This document already exists, and… a range of data is already mapped out, so we can look at crime data in here and that sort of thing. So that's currently used as part of the normal [licensing] processes. And there are data sets that are mapped against the four existing licensing objectives. But for this pilot, we've added some heath data… so the first one we've added is the health deprivation data..." (Public Health)

Alongside the evidence from the mapping tool, primary research from a local survey of individuals in treatment which included information on where they purchased alcohol and the times they purchased was included.

"We did a bit of a resident survey a few years ago and one of the questions in that was: Do you believe that people being drunk or rowdy in a local area is an issue? So we've got the percentage of people saying it's either a big problem or a rather big problem." (Public Health).

Based on the information provided both applications were rejected on the grounds that they did not 'promote' (support or actively encourage) the two licensing objectives.

The feedback from the Committee Chair and its legal advisors was that it would be important to include the barrister's opinion about the applicability of area based data as opposed to premises specific based data in future representations as there was still a common misconception among licensing about this, to counter the view that all data needs to be specific to the licensed premises.

Going forward, the chair and legal advisors suggested that in all representations the barrister opinion should be included re area based data as opposed to premises specific, as this is still a common misconception among licensing and the information provided was a good reminder.

The inclusion of data from neighbouring areas was seen to be relevant and helped to show cumulative impact across a wider area; and the comparisons with other LSOA's added context. The Committee Chair and legal adviser were satisfied that the empirical evidence used showed the statistical likelihood of harms, and advised that the more local and recent the empirical research, the more influential it would be.

They also said that data could be more powerful when allied to a monetary value, for example hospital admissions cost £x million per year.

"Extending the opening hours of these premises would increase the availability of alcohol and potentially increase alcohol-related harm for this area, which already has one of the highest levels of alcohol-related harm in the borough. Therefore, it is considered that the proposed variation will not 'promote', ie support or actively encourage; further the progress of the Promotion of Wellbeing and Public Health, objective."
(Council legal adviser and Chair of Licensing)

"I think since we've had some more of that training, that's provided a lot more reassurances and actually increased our knowledge that it doesn't necessarily have to be linked to that premises when we're doing an objection or a representation. So I think that's been really useful. I think that's probably changed quite a lot of people's views over the last few months, to be honest … It feels like there's much more confidence in the process from ourselves, I guess, in public health. Where actually we can provide some much more valuable contribution than perhaps we've been able to do in the past with some of our thinking." (Public Health)

Wigan's experience in the pilot and through the mock hearing has meant they reconsidered their expectations for licensees to indicate more clearly how they were promoting the existing objectives.

Case study: Current objectives vs HALO Cornwall

As the Cornwall public health team had limited experience of licensing hearings they chose to hold an exploratory workshop with licensing colleagues, including committee members, licensing officers, police and legal advisors. The experts were asked to examine the available data under the existing objectives and to come to a view on whether an additional health objective would be necessary.

They were asked to:

- agree if the data presented was evidential
- see if health data was enough to propose conditions - or objections - on its own
- help public health officers understand the value of health data to existing licensing objectives
- to suggest what conditions would be reasonable based on the evidence presented

The public health team presented two cases: a large venue consisting of a pub, club & restaurant; and a town centre pub with a late licence. The aim of the workshop was to see what difference a health-related objective (and the capacity to consider health information) would have made to the two retrospective planning applications, which had already been processed under the existing licensing objectives.

Focusing on acute harm and violence in the night time economy, the public health team used their risk identification dashboard to produce a range of data and maps that provided a picture about alcohol harm around the premises. These included:

- alcohol related hospital admissions
- residents in alcohol treatment
- alcohol related violence
- rowdiness/disorder/antisocial behaviour/street drinking
- alcohol related road traffic collisions (RTCs)

The information was presented alongside additional and supportive data, which included assault data from A&E, noise complaints, domestic violence incidents, and information about school-age drinking from a local survey.

The expert group thought that the information provided on health harms spoke to all four existing licensing objectives and that a licensing committee would have refused the applications. The consensus was that the evidence as

presented helped the committee focus on health harms and also helped build up local context in both cases.

Participants in the workshop were split on the extent to which health-related data was sufficient to make representations without contributions from other responsible authorities. They were, however, unanimous in saying that public health, working in partnership with other responsible authorities, would contribute to genuine partnership and enable a more comprehensive range of information to be deployed.

It was recognised that the majority of the data presented would already be accessible to licensing officers, but the format of the presentation enhanced its effectiveness. The maps and risk identification dashboard made it easy to see the logic of how a premises impacts upon the health and other harms being experienced in the locality.

The workshop participants were divided on the need and case for a public health licensing objective. Half agreed that it was needed and felt they could refuse the applications under a health objective and that it would enhance the ability of the licensing committee to make decisions to the benefit of their local community. The other half felt public health, and the data presented, were relevant to all the current four objectives and, as a result, didn't see the need for a specific public health licensing objective as what was presented fitted under the current four. They did see a case for the existing objectives and guidance to be strengthened to reflect the role of public health in licensing decisions.

Outside of the workshop, the police, in dialogue with one of the premises, used the data collected as part of this project to negotiate with the premises to make some practical changes to the way the premises was run:

- almost exclusive use of plastic glasses (excluding customers in the VIP area and for those ordering Champagne)
- moving the smoking area from the front of the premises to the rear
- a redesigned entrance for queue control, reducing the need for passers-by to step into the street and risk being involved in a traffic accident

In addition there were also discussions with other parts of the council about relocating a taxi rank which was identified as a flashpoint/hotspot for alcohol related violence and RTCs.

The process has led to closer working between public health and other responsible authorities in the county, in particular with the legal team, to

ensure a system of regular (annual) reviews of the cumulative impact policies. Doing this should enable responsible authorities to deal more effectively with challenges around their evidence of harm becoming out of date.

General feedback

Feedback from all the areas involved in the pilot suggested having a public health licensing objective would reinforce the legitimacy of health representations, and increase the confidence of other responsible authorities and licensing committees in taking account of health data in their deliberations. The participants who went through the experience of conducting mock hearings/workshops were in a better position to answer the questions on the feasibility of a public health licensing objective, and the constraints felt by public health within the current four licensing objectives.

It is clear from the feedback from the project that if a public health licensing objective is to be considered the wording of the objective and supporting guidance would be critical. Without a clear definition stakeholders may struggle to conceptualise how a health objective would be operationalised.

“But for me the starting point in public health going forward has to be: what’s your objective going to look like? What is it actually going to say? It needs someone to define what a health objective would be - the working of it - and then everybody can actually work from that and say: ‘Right, if that’s going to be the objective, that’s how it fits here.’” (Police)

Conclusions

The ASP pilot worked at pace over a short timescale to provide a range of useful insights, identify and gather a range of health and wellbeing evidence and data, and to develop bespoke local mapping tools to support licensing work.

The tool itself was welcomed as a useful addition to public health's role as a responsible authority, and was seen as having wider scope in supporting not just licensing work, but also public health commissioning and other local authority teams. The pilot helped areas think creatively and practically about how to access and utilise a range of available health information in ways applicable to local licensing practises. However, there is still scope to improve and work to be done in getting across the benefits public health can bring within the current Act.

The work highlights ongoing challenges and areas of improvement which can be framed under three domains.

Operational

The capacity of public health teams to engage in alcohol licensing work and the analytical capacity to work with data. Local public health teams will need to find analytical capacity in order to make the most of the ASP, and develop data sharing agreements with other parts of the health system where necessary. They will also benefit from developing processes for prioritising alcohol licensing work.

Skills

The ability of public health teams to present health data in a format and context that licensing committees can assimilate in their decision making process. The ability of those in licensing to understand and make the best use of public health's contribution to promoting the licensing objectives.

Training and support for public health teams on using the ASP and how to present information could help improve their effectiveness. As could extending training on the proper role of public health as a responsible authority to all responsible authorities and the licensing committee.

Where data is used it needs to be part of a wider narrative about promoting the licensing objectives and viewed in context of the local area. Public health teams need to familiarise themselves with and take into account the section 182 guidance and case law.

Custom and practice

The existing custom and practice in a local area was an important factor in the level of engagement and effectiveness of public health in engaging with alcohol licensing. Responses highlighted a mixed view on Public health's role and there wasn't a clear consensus on the reach of public health within the current Licensing Act. This had an impact on the openness to engagement, acceptability of data within licensing and influenced the responses that came out of the work. The different views also lead to differing interpretations of the Act and what was permissible, especially when it came to area based vs single premises evidence.

Public health engagement within licensing and what is considered possible is clearly enhanced or restricted by the custom and practice of the local licensing arrangements and its practical implementation of the licensing regime. While barriers exist, the pilot areas identified more scope within the current objectives and provided examples of the positive role public health can play in providing effective engagement within the current Act.

There is a clear need to develop strong partnership structures, and the ability to build a common understanding of public health's role in alcohol licensing alongside demonstrable impact in cases were all seen as important in building trust and effective working arrangements.

There are a growing number of examples of effective engagement which highlight how their role is compatible with the existing licensing objectives which should be shared to improve sector led improvement in this area of public health's responsibilities. Consideration could be given to strengthening the guidance around the current objectives to reflect the role that public health plays.

A public health licensing objective

Even with the four current objectives, the absence of a specific public health licensing objective was seen by many participants in the project to be a barrier to public health's role, with some arguing that its absence diminished public health's standing as a responsible authority.

The areas that experimented with mock hearings or who presented their evidence to workshops provided examples of how local areas could establish evidence relevant to decisions based on a public health licensing objective but also highlighted challenges in doing so. If a public health licensing objective is to be considered the wording of the objective and supporting guidance around it will be key.

There is a strong desire from many within the public health and licensing community to make progress within licensing and achieve a fifth health objective. This report highlights ways to improve engagement within the current Act and potential options for effective processes for a health objective through the work of the mock hearings. While challenges still remain, this report moves the conversation along and PHE will continue to be supportive to public health teams within their existing role and to build the local evidence base for public health participation.

Next steps

Based on the findings of this report, PHE has developed the ASP into a nationally available resource. In line with our digital first strategy this is a web based resource which we will continue to update with information and case studies.

While designed for public health teams the ASP will be accessible to all responsible authorities and can be accessed on the .GOV website: https://www.gov.uk/guidance/alcohol-licensing-a-guide-for-public-health-teams

We hope the information included in this report helps local areas to explore and address ongoing challenges for effective public health engagement in promoting the objectives of the Licensing Act. Local public health teams and their partners should continue to build the evidence base of effective public health engagement in alcohol licensing through the use of the ASP.

We encourage public health teams working on licensing to work collaboratively with their partners to maximise their role as a responsible authority, and to ensure that the public's health is a consideration in local licensing policies and is represented in licensing forums and partnership groups.

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