Assessing the feasibility of using health information in licensing decisions: A case study of eight local authorities in England

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Overview / Contents

• Current arrangements for alcohol licensing in England and Wales and guiding principles / rationale

• Recent structural changes in public health and licensing in England and Wales (and UK as a whole)

• Prospects for increasing the input / use of health information / health data sources into licensing application decisions and other aspects of local alcohol policy (a main focus of which will be PHE’s Analytical Support Package).
Current licensing objectives in UK

In England & Wales

1. Promoting the prevention of crime and disorder
2. Promoting public safety;
3. Promoting the prevention of public nuisance
4. Promoting the protection of children from harm.

In Scotland:

5th licensing objective in 2005 (implemented in 2009), ‘Protecting and improving health’ (no panacea!)
Aside: Cumulative Impact Policies *

A cumulative impact policy creates a ‘rebuttable presumption’ that applications within the designated cumulative impact area for new premises licences or variations that are likely to add to the existing cumulative impact will normally be refused if relevant representations are received.

It is for the applicant to demonstrate that their application would not add to the cumulative impact of such licensed premises in the area.

*More pro-active approaches to licensing controls such as CIPs now associated with higher likelihoods of reductions in alcohol related crime and disorder and alcohol related hospital admissions in England and Wales: two recent papers by de Vocht et al.*
PHE Analytical Support Package: Components

Subject of the main evaluation effort

1. Alcohol harms and licensing data library: This provided a list of relevant datasets and information sources organised by relevant licensing objective.

2. Specific signposting and support in accessing and using databases and mapping tools including PHE’s Local Health tool. This provided access to interactive maps and reports at both middle layer super output areas (MSOA) and local authority levels.

3. Guidance on how to collate information collected from primary data (e.g. via local surveys) to support engagement in the licensing process. This section also included guidance on how to set up information-sharing agreements to access data that is available but not yet accessed by responsible authorities.
The brief for the work (PHE)

Testing out the functionality of the analytical support package within the existing licensing regime and assessing its use in supporting a public health objective. This pilot will explore how the resource could be used to support areas to identify, gather and communicate local health data.

Health as a licensing objective (HALO). We need to understand the benefits that having a health objective could offer. We also need to check what data and processes are needed to support the introduction of a fifth public health licensing objective, and how these could be applied if a health objective was introduced.
Alcohol harms and licensing: Available data resources

- Excel format (for ease of adaption / modification / enhancement)
- Initially developed in 2014 and piloted by LAAAs and Knowledge Hub group
- Range (60+) of potential indicators – not just public health
- Organised by objectives in the Licensing Act 2003 - additional licensing objective 'health and other'

**Indicators are defined by a number of headings**

- Licensing objective
- Data Set/Item
- Source
- Availability
- Regularity
- Coverage
- Granularity
- Quality and utility
- Potential Use
- Confirmed as available
Components of Evaluation

1. The utility of the ASP in facilitating access to the types of information that would be useful to incorporate health related concerns into evidence that may challenge the viability of new licence applications.

2. The perceived potential benefits of a new and dedicated health associated licensing objective (HALO) and the extent to which that might enhance the legitimacy of public health as a responsible authority.

3. (Broader examination of...) the role of public health in alcohol licensing and the development of local government policy responses to the challenges of hazardous and harmful drinking.
Methods of data Collection

I. Five baseline semi-structured interviews (with at least two informants) to establish what mechanisms were in place for dealing with licence applications before implementing the ASP

II. Three mock ‘licensing hearing’ type scenarios, that involved four participating LAs

III. Two ‘shared learning events’ with directed discussions related to the three components outlined previously (after one month and then at project conclusion) and from which roundtable discussion summaries were included in the analysis

IV. Four end of trial period focus groups with a total of 31 responsible authority members across the eight sites... Resulting in/...
### Pilot sites participating

<table>
<thead>
<tr>
<th>Pilot LA area</th>
<th>Region</th>
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<tbody>
<tr>
<td>Gateshead</td>
<td>NE</td>
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<td>Co. Durham</td>
<td>NE</td>
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<td>Leeds</td>
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<td>Southampton</td>
<td>SW</td>
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<tr>
<td>Portsmouth</td>
<td>SC</td>
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A wealth of data...!
### Participant roles in four focus groups

<table>
<thead>
<tr>
<th>Responsible Authority/Position Held*</th>
<th>No. of participant’s roles</th>
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<tbody>
<tr>
<td>Environmental Health</td>
<td>5</td>
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<tr>
<td>Trading Standards</td>
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<td>Police</td>
<td>2</td>
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<tr>
<td>Licensing</td>
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*Total no. of participant roles* 31
Early Impressions were…

Clear from the outset why these areas are keen to participate in HALO pilot: All baseline conversations demonstrated:

• Strong willingness to engage with alcohol harm reduction

• Record of exploring novel data local sources to complement what was already available

• Advanced levels of visualising localisable data (own mapping tools in use / being developed)

• Significant inter-agency working around the common purpose of tackling excessive / harmful consumption

The specifics and selected highlights from baseline/…
Findings at end of pilot  
SELECTED HIGHLIGHTS FROM PARTICIPATING LA’S
Three Overarching Themes

1. Utility and acceptability of ASP as an information resource (for accessing & presenting information) in the licensing and alcohol policy evaluation setting

2. The potential added value as well as any likely drawbacks of introducing a new licensing objective based around health

3. Current status of the public health contribution to local authority alcohol licensing and recommendations for how the role might be further developed
Utility and acceptability of ASP...

In principle, the ASP was seen as a welcome and convenient resource especially as it could serve as a single repository for all licensing relevant information:

*I think we’re grateful that we’ve got this, because what we don’t want is people having to go to five different sources to get what they need...*  
**LA Public Health Specialist**

**Needs to be seen against issues around data resolution:**

*So when you’re really trying to drill down to, oh, is this premises having an impact on street a, street b, street c, MSOA is never going to be robust enough...*  
**LA Information Analyst**

**Encouraged / facilitated use of novel linked data sources:**

*But I think this process is making us think about potential other avenues for other more local data. Like housing, the suicide data, the NHS health check (and) I think there’ probably other avenues we might not have currently gone into...*  
**LA Information analyst**

- **MSOA**: medium level super-output area - for census statistics in England covering between 5000 and 15,000 persons
Utility of ASP (cont’d): Accessing & Presenting Information

The level of access to, and granularity of, health data varied between areas, with accessing HES data cited as the area in need of most improvement: often dependent on ad-hoc arrangements like shared analytical posts (LA & NHS) – leading to is own issues around capacity (and implications for ‘end-user friendliness’):

“It’s just with, obviously, our (restricted) 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...
ASP as prompt to utilise novel data sources / indicators

**Novel data sources / indicators included:**
- noise complaints
- hospital stays for alcohol harm
- alcohol-related morbidity
- domestic abuse
- Emergency contraception data from pharmacies...

All of course useful in the right context, but over-riding importance of presentation was repeatedly highlighted...
The potential benefits (and drawbacks) of a dedicated 5\textsuperscript{th} Objective (HALO)

Likely to enhance substantially the credibility of public health led representations:

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... LA licensing officer

A separate participating LA were exploring the potential of adding health to enhance the evidence case for existing cumulative impact areas:

From the perspective of existing cumulative impact areas, the introduction of a health objective would enable them to be strengthened to take account of small area clusters of alcohol related ill health. Since CIP areas need to be reviewed regularly to maintain their relevance, adding health impact would be relatively straightforward, thereby getting around the issue of single premises attribution... LA legal advisor / licensing specialist
Data in Context & Importance of Training

There was acknowledgement of the need for public health colleagues, as well as other licensing panel members to be trained in both applying and presenting data (as well as interpretation):

“\textit{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.
Wider training needs and requirements

I think the other danger of the analytical toolkit is that it gives Public Health false confidence. I think that’s coming through. We’re good data handlers. But in a very direct correlation, kind of, way… And that’s not...(necessarily) what’s needed or what’s possible here)... LA Public Health Specialist

‘councillors and lay committee members are not accustomed or all that comfortable ‘being blinded by science’… you could just see their eyes glazing over...Independent observer (regional public health role)
Public health roles in alcohol licensing (and alcohol harm reduction policies)

Subtopics identified:

1. A working definition of what a public health objective would look like *
2. Format and strategy for building successful representations
3. Training needs and requirements (for public health and the wider stakeholder group)
A working definition of what a public health objective would look like

“What’s the fifth objective doing to be?” Now the wording of objectives is very important. The protection of children from harm isn’t to do with stopping children getting abused while they’re being abused, it’s about preventing that in the first place – without a working definition of the health objective, it just means it’s all things to all people. LA Licensing Officer

It was well and good going to the committee and saying we’re doing it under the public health objective, but it was pulling it all out of the air thinking, well, what do we actually mean? We don’t even know what one would look like. Or what the definition of it would be. What’s the...? What would be the aim of an objective? LA Licensing Officer
Recent Developments II

Recently completed analysis in Durham – by Chris Allan (final year specialty registrar) demonstrated:

Over-riding importance of deprivation as an independent local predictor of alcohol harms – leaving open the possibility of local area level deprivation being ‘evidence enough’ that an area should be merited greater protection from increased availability etc..
Format and strategy for building successful representations

Related to the need to move away from pre-occupation with single premises:

Unless any new objective comes an increased weighting –that (lets) you take account of an area (e.g. local deprivation), rather than a specific premises, it’s going to be meaningless. Environmental health officer

This area has got high deprivation. We know that that will mean that people in this area have an increased risk of harm. Therefore additional hours or additional provision/supply in this area, we believe, is likely to increase the potential harm for these individuals. LA public health specialist

...the committee would say, well, if the police aren’t making a representation, why are you talking about crime and disorder, saying it’s a problem? Police licensing specialist officer (follow up interview)
Project Limitations

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.

The pilots were short and the evaluation was carried out within a tight timeframe: meaning some aspects of the ASP were more thoroughly ‘tested’ than others; As would be expected in a full roll-out, participating areas took different approaches to testing the ASP.
Conclusions

Constraints around using health information in alcohol licence decision making are not restricted to the presence or absence of a dedicated HALO.

While such an objective might enhance the legitimacy of a public health role, improved access to localised health information, stronger collaborative working with other stakeholders and training in how to contextualise evidence for local council committees will all be critical to improving local alcohol harm reduction through licensing.

Place based initiatives / perspectives seem to be the most promising way forward whether this is mediated through an expanded jurisdiction / provision within guidance for cumulative impact areas or a broad ‘health & well-being’ interpretation attached to a new licensing objective specifically related to health.
An Evaluation of a PHE Analytical Package to support the use of health information in Licensing representations

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Background

Changes in recent years to the public health infrastructure in England, including the inclusion of directors of public health as responsible authorities in relation to alcohol licence applications, have led to renewed attention on the prospects for a fuller consideration of health related information within the licensing process. The current study was commissioned by the Home Office and Public Health England and, the viability of introducing a new licensing objective around health specifically linked to cumulative impact policies was evaluated in selected high need areas. While viable, public health teams in pilot areas expressed the need for more support to be able to identify, gather and communicate local health data. We evaluated the utility of three component support package (which consisted of a data-access compendium, information sharing agreements and localised mapping software) for this purpose and the extent to which this could help local public health teams contribute effectively to decision making around alcohol licensing.

Key findings

The analytical support package provided a useful single point of access for health related information in licensing, although it was clear that a more effective integration of health data in licensing decisions will require additional inputs and resources across three areas:

1. Data Resolution: Although data at LSOA was useful for setting area-wide context, more localised representations within a licensing scenario would often require health information to be accessible at a higher resolution (e.g. for more geographically dispersed populations).

2. Data Timeliness: Despite some pilot areas having data sharing agreements with local health data agencies, there were remaining concerns over the reliability and validity of this data, in particular in relation to timeliness, in order that the information presented can withstand likely challenges.

3. Training for licencing hearings Presenting health data to legal teams, such as barristers as well as to council officials was a challenge for RA’s unfamiliar with this format, so there was a consensus that further training in this area would be required.

More generally, regarding a fuller integration of public health within the alcohol licensing process, the most critical lessons to emerge from the mock hearings and expert panel reviews were:

1. Accommodating the responsible authority role for public health teams worked best for those authorities with an existing strong record of joint working.

2. Public health are more effective when they work in partnership where possible to make representations in cooperation with other responsible authorities even where they consider the health evidence to be sufficient.

3. Combined representations will always make for a stronger case and will help to embed health information as part of the typical evidence case. Even with good health evidence however, the current absence of a fifth objective on health can make it difficult for Public Health representations to receive due consideration irrespective of how compelling the evidence might be.

4. There needs to be careful consideration as to how a new specific ‘public health objective’ or fifth licensing objective around health would be worded and what representations based on such an objective would look like. Critical thinking is needed about how an objective could be formulated such as to make it meaningful and assessable from a licensing perspective and how an objective could be framed within the timeliness of the process.

Methodology

This was a qualitative study involving interviews with seven purposively selected local public health and licensing teams from four English regions. Respondents were all responsible authority (RA) representatives and included Public Health, Intelligence Analysts, Police, Trading Standards, Environmental Health and Licensing Officers. The current report draws on information collected using four distinct methods: a)Baseline interviews; b)Mock licence hearings / review panels of hypothetical applications; c)Shared learning events; d)Focus group interviews. Interviews and focus group sessions were fully transcribed and emergent themes were grouped into four overarching themes of: (i) The functionality and acceptability of the analytical support package; (ii) Use of health data; (iii) The licensing process; (iv) Public Health as a fifth licensing objective.

Figure 2. LA2 health data used to construct ‘traffic-light’ dashboard

This project was funded by the NIHR Public Health Research Programme Health Services Research Collaboration. The views and opinions expressed are those of the authors and do not necessarily reflect those of the NIHR or the Department of Health.

References:

5. Egan M, Brennan A, and Nicholls J. Public health are more effective when they work in partnership where possible to make representations in cooperation with other responsible authorities even where they consider the health evidence to be sufficient.
6. Changes in recent years to the public health infrastructure in England, including the inclusion of directors of public health as responsible authorities in relation to alcohol licence applications have led to renewed attention on the prospects for a fuller consideration of health related information within the licensing process. The current study was commissioned by the Home Office and Public Health England and, the viability of introducing a new licensing objective around health specifically linked to cumulative impact policies was evaluated in selected high need areas. While viable, public health teams in pilot areas expressed the need for more support to be able to identify, gather and communicate local health data. We evaluated the utility of three component support package (which consisted of a data-access compendium, information sharing agreements and localised mapping software) for this purpose and the extent to which this could help local public health teams contribute effectively to decision making around alcohol licensing.