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Assessing the feasibility of using health information in alcohol licensing decisions: a case study of seven English local authorities

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Abstract

Background: In 2011, local authority Directors of Public Health were designated as one of the responsible authorities for all alcohol licensing decisions in England. Since there is no explicit licensing objective around health, any representations need to be based on the existing objectives oriented around public safety, prevention of nuisance, child protection, and crime prevention. We aimed to appraise the benefits of an analytical support package developed by Public Health England in facilitating the use of health-related information in local licensing decisions and the prospects for a dedicated health-related licensing objective.

Methods: A case-study methodology was used to invite nine local authority pilot areas to participate (one declined) on the basis of broad geographical representativeness across English regions and qualifying criteria that included a dedicated public health lead for alcohol licensing. Each participant was provided with an analytical support package consisting of a compendium of health-relevant data, local mapping software, and guidance on setting up data-sharing agreements. Key informants, including those in public health and licensing, were interviewed at baseline and after 8–12 weeks. Three mock licensing hearings, in which hypothetical licence applications involving health-related evidence were assessed by a panel, were conducted during the intervention phase. Follow-up focus group interviews involved a total of 31 informants across seven sites. A quantitative assessment of licensing activity was derived from Home Office statistics.

Findings: Perceived difficulty in proving that a new licence would have a damaging impact on health had the effect of discouraging objections from public health teams. Obtaining timely access to localised health information was often problematic. There was also a degree of mismatch between the predominantly data-oriented approach by public health teams and the need for contextualised evidence for presentation to councillors. Early findings, however, demonstrated that several local authority areas were able to overcome these issues by incorporating novel indicators of health harm and using the mapping tools as a way of engaging their licensing committee.

Interpretation: Constraints around the more effective use of health information in the alcohol licensing process are not restricted to the presence or absence of a dedicated health-related licensing objective. Although such an objective might enhance the legitimacy of a role for public health, more streamlined access to localised health information, stronger collaborative working with other responsible authorities, and training in how to contextualise evidence will be crucial to improving local alcohol harm reduction through licensing.

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Contributors: JDM developed the protocol in response to the funding call, undertook baseline interviews, worked on the analysis, and co-wrote the abstract. ZS undertook in-depth follow-up interviews, worked on the analysis, and co-wrote the abstract. FdV was involved in the study proposal, protocol development, and appraising data sources included in the support package. MS led on the development of the analytical support package and Public Health England commissioning brief as well as project management and assisted with the interpretation of findings. JN provided expert input on local licensing policy and advised on research design and interpretation of findings. JL co-developed the protocol with JM and provided methodological support throughout the course of the project.

Declaration of interests: We declare no competing interests.