

Public Health involvement in alcohol licensing decisions: policy, partnerships and professional ideology

A thesis submitted to Middlesex University in partial fulfilment of the requirements of Doctor of Philosophy

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August 2018

Abstract

The Police Reform and Social Responsibility Act 2011 added 'health bodies' as Responsible Authorities within licensing decisions and, in practice, Directors of Public Health undertook this role. Despite the Act enabling Public Health departments to engage with alcohol licensing decisions to facilitate the inclusion of Public Health in licensing, wide variations in involvement levels by Public Health departments persist. If this variation continues, it will potentially create a missed opportunity relating to potential improvements in population health relating to alcohol.

This research was funded by Alcohol Research UK (now merged with Alcohol Concern). The subject matter is an important area of research, and to date, has only received limited attention.

This research adopted an approach which allowed the exploration of the experiences of Public Health professionals engagement in alcohol licensing decisions in London. The specific research questions were:

- How is national policy around the role of Public Health in alcohol licensing, translated and implemented at a local authority level?
- What are the factors that facilitate or impede Public Health engagement in alcohol licensing partnerships?

Qualitative data was collected through twenty-one in-depth interviews in a purposeful sample of London boroughs, consisting of five areas (six London boroughs as one Public Health department covered two boroughs). This was combined with analysis of relevant documentation and field notes of observations of fourteen Licensing Sub-Committee meetings in one London borough over a seven-month period. Thematic analysis of data was completed to identify emerging themes and to fully answer the research questions.

This study provided new knowledge, plus added to existing knowledge, with key themes relating to:

- The role of Public Health within licensing decisions
- Engagement and challenges to licensing partnerships

Acknowledgements

This thesis would not have been possible without the guidance and support of the supervisory team of Professor Betsy Thom, Dr Rachel Herring, Professor Anthony Goodman and Professor Carmel Clancy.

I would also like to acknowledge Alcohol Research UK who sponsored this research.

The professionals and organisations who participated in this research require acknowledgement, as without their willingness to share information and openly discuss their experiences, this study would not have been completed.

Finally, I would like to acknowledge my family. To my husband, thank you for your never-ending support and encouragement and to my children, always follow your dreams.

The quote below by Stephen Hawking reflects my Ph.D. journey, “however difficult life may seem, there is always something you can do, and succeed at. It matters that you don’t just give up”.

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List of Acronyms

AAFs – Alcohol Attributable Fractions

AFS – Alcohol Focus Scotland

ALRUK – Alcohol Research UK

CCG – Clinical Commissioning Group

CIP – Cumulative Impact Policy

CIZ – Cumulative Impact Zone

CMO – Chief Medical Officer

CST – Community Safety Team

DAAT – Drug and Alcohol Action Team

DCMS – Department of Culture, Media and Sport

DoH – Department of Health

DPH – Director of Public Health

DPS – Designated Premises Supervisor

EMRO's – Early Morning Restriction Orders

FPH – Faculty of Public Health

GLA – Greater London Authority

H&WBB – Health and Well Being Board

HMSO – Her Majesty's Stationery Office

HoL – House of Lords

HVVD – High Volume Vertical Drinking

IAS – Institute of Alcohol Studies

IoL – Institute of Licensing

LAPE – Local Alcohol Profiles for England

LGA – Local Government Association

LNL – Late Night Levy

MUP – Minimal Unit Pricing

NHS – National Health Service

NTA – National Treatment Agency

NTE – Night Time Economy

OECD – Organisation for Economic Co-operation and Development

ONS – Office of National Statistics

PCT- Primary Care Trust

PH – Public Health

PHE – Public Health England

RA – Responsible Authority

SoLP – Statement of Licensing Policy

SSLP – Safe, Sociable London Partnership

TEN – Temporary Event Notice

UNICEF - United Nations International Children’s Emergency Fund

1. Introduction

This PhD was funded by Alcohol Research UK (ALRUK)¹ and Middlesex University through a studentship. The area for investigation set by the funding bodies was ‘alcohol licensing at local levels: stakeholders’ roles in decisions making’. Despite a general area of investigation being pre-determined, the topic was sufficiently wide to allow the research to develop into a thesis, that both added new knowledge in respect of licensing decisions and made a unique contribution to understanding on this subject.

My educational and employment background will have influenced the decisions made during this study. I had a background in general nursing before moving into the field of addictions after completing a post graduate qualification. After gaining work experience in various addiction settings, I returned to university, completing a Master’s in Public Health. I then secured a position working within Smoking Cessation before commencing work as a Health Development Manager in a London borough. This joint post worked across the National Health Service (NHS) and local government, being located within a Drug and Alcohol Action Team. By the end of this employment, my role was Senior Public Health Commissioning Strategist, with responsibility for the Public Health teams’ work around alcohol licensing. Having held responsibility for reviewing alcohol licensing applications and working in partnership with other Responsible Authorities, I was very interested in the topic that this PhD was set to examine. Due to previous experience within Public Health, I wished to concentrate the study mainly on the role that the stakeholder of Public Health played within licensing decisions. My own professional identity is primarily as a Public Health professional and a nurse, this background adds a medical element to my identity. As I have also worked and studied around health inequalities and addictions, I also identify with social determinants of health models. My overall professional identity is therefore mixed with elements from differing professional groups incorporated into my current practice.

Within the London borough that I was employed, although some progress had been achieved in relation to Public Health engagement within licensing, improvements were still necessary. Overall, the involvement of Public Health within the existing licensing partnership was not

¹ Alcohol Research UK merged with Alcohol Concern in 2017. Now called Alcohol Change

being optimised. Anecdotally, from attendance at regional licensing events and networking with colleagues employed in other areas across London, it was apparent that some boroughs were experiencing difficulties in operationalising the role of Public Health departments within licensing. There was wide variation across London relating to each borough's Public Health department's level of involvement in licensing and my initial interest in this topic originated from a desire to gain an understanding of potential reasons behind this difference.

This PhD commenced during autumn 2014, three years after the Police Reform and Social Responsibility Act (2011)² was implemented and two years after the Health and Social Care Act (2012)³. The Police Reform and Social Responsibility Act (2011) saw the introduction of 'health bodies' as Responsible Authorities (RAs). In practice, Public Health departments eventually undertook this role. In 2012, the Health and Social Care Act followed, heralding a radical transformation of the NHS with the abolition of primary care trusts (PCTs), establishment of Clinical Commissioning Groups (CCG's) and a move of Public Health departments from the NHS into Local Authorities (LAs). For Public Health, in addition to the relatively new role of being a Responsible Authority, there was a transition into a new location of local councils within England.

At a national level in relation to policy, the national government began a process of localism, allowing local authority areas to receive increasing amounts of devolved powers over policy decisions, instead of centralised policy development followed by local implementation. The Localism Act of 2011⁴, introduced legislation that aimed to, "achieve a substantial and lasting shift in power away from central government and towards local people". This policy, termed as localism gained popularity in London, with the organisation named London Councils⁵, who represented the thirty-two borough councils and the city of London, leading calls in London for devolution. In 2016, the Cities and Local Government Devolution Act⁶ came into force. This act aimed to "devolve far reaching powers over economic development, transport and social care to large cities which choose to have an elected mayor". During the period of this

² <http://www.legislation.gov.uk/ukpga/2011/13/contents/enacted>

³ <http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted>

⁴ <http://www.legislation.gov.uk/ukpga/2011/20/contents/enacted>

⁵ <https://www.londoncouncils.gov.uk/who-we-are>

⁶ <http://www.legislation.gov.uk/ukpga/2016/1/crossheading/reports-about-local-devolution/enacted>

research (2014- 2018), a series of devolution pilots commenced across London, including a specific project focusing on licensing in one borough.

Whilst this research could have covered the entire UK or England, the focus of this study was London. This decision was taken based on varying licensing systems across the UK. Whilst the same licensing legislation is applicable to all areas of England, regional variations in policy remain. By selecting the region of London, investigation across one entire geographical area was possible. Overall alcohol consumption rates are lower in London in comparison to other areas of the UK, therefore within the first Chapter of this thesis, consideration is given to whether London constitutes a special area in relation to alcohol intake.

The United Kingdom (UK) was experiencing several changes in relation to politics and policy processes, during the completion of this research. The UK had entered a period of austerity. This aimed at reducing spending within the public sector and therefore local authorities. During the completion of this research, spending on local authority services from central government continued to substantially reduce. Although Public Health departments transferred from the NHS to local councils with a 'ring fenced' grant, the overall Public Health grant has also reduced. The ring fence will only remain in place until 2019 (Alcohol Policy UK, 2017). The background to this research was within a context of policy change, political uncertainty and reducing resources.

This thesis begins with the first Chapter (1), providing a **short introduction to the research**, along with a summary of the contents of each Chapter. Chapter Two (Background) provides an **overview of available literature** relating to alcohol and alcohol licensing. This sets out information on alcohol consumption patterns in the UK and includes a summary of variations in population level data on alcohol consumption. Different policy interventions, which aim to control the availability of alcohol are outlined, with a specific focus centring on the main topic of this research, namely alcohol licensing. Licensing decisions as a measure of control over alcohol availability, have been demonstrated as affecting the amount of alcohol consumed (Babor et al, 2010). As alcohol licensing is the focus of this research, this is the policy option discussed in most detail in the background Chapter. Within the background Chapter, the legislation most closely aligned with licensing in the UK, is outlined.

As previously mentioned, the stakeholder group of Public Health is the focus of this thesis. Chapter Two concludes with a discussion over the increasing involvement of Public Health departments within alcohol policy work and licensing. There are several regional and national organisations who contribute to alcohol policy work, with a smaller number of organisations specifically involved with Public Health involvement within alcohol licensing. To provide readers of this thesis with clarity, each organisation is named and a short summary of their role within licensing decisions is provided.

During an initial examination of available literature, it emerged that whilst there was a large amount of research relating to the topic of alcohol, on the specific area of Public Health involvement in licensing, there were few research studies available for review. Public Health was a relatively new Responsible Authority when this research began, which could potentially have been a reason behind the lack of published work on this subject. As there is a lack of research studies on Public Health involvement within licensing decisions, this is an area where this study provides new knowledge.

In Chapter Three, the focus of the thesis turns to **policy processes, partnership working and professional identity**. The addition of Public Health as Responsible Authority is an example of a national policy that produced different results across London after implementation. Within this research, the implementation gap between national policy development and implementation at local levels is investigated. The **conceptual framework and theories** connected with this study are discussed in detail within this Chapter. The main conceptual framework relates to policy formulation and policy implementation and draws on the work of Buse et al (2012) on health policy processes. Within this, partnership working is used as a key mechanism in examining the 'implementation gap' between policy formation and delivering policy at local level (Buse et al, 2012)

Part of this research examined how policy formulation and implementation is achieved and whether partnership working was a crucial element within this. In searching for possible explanations relating to facilitators and barriers to partnerships, the work of Freeman and Sturdy's (2015) on knowledge within policy and Gieryn's (1999) theory on the cultural boundaries of science became relevant. Work by Freeman and Sturdy (2015) became relevant to the research in relation to Public Health's new role within licensing, requiring

Public Health to gain new knowledge around licensing policy. Gieryn's (1999) work connected to this study in relation to the dominant professional identity of Public Health and the implications of Public Health adopting a certain identity within licensing work with the other Responsible Authorities. Within Public Health work at a national level, a partnership approach to all work streams is encouraged. In this Chapter the available literature which defined partnership working, along with reasons behind the rise in the use of a partnership approach is examined. Commonly used models of partnership from the literature are discussed along with potential factors operating as enablers and barriers to collaborative working.

In the final sections of this Chapter (3) the professional identity of Public Health professionals is examined. The dominant framework of licensing is a legal system, despite licensing decisions not being made within a court of law⁷. Working within a legal framework is new for senior Public Health professionals who traditionally align with medicine whilst working within the National Health Service (NHS). The role as a Responsible Authority coupled with a new working environment, potentially impacted on the professional identity of Public Health. In addition to identity changes triggered by moving to local government, are questions over the ability of Public Health professionals to apply the frameworks of evidence-based medicine and science to the quasi-legal system surrounding licensing decisions. In addition to the main conceptual framework and related theories, the work of Lipsky (1980, 2010) proved useful in relation to understanding 'Street Level Bureaucracy'. Lipsky's (1980, 2010) work relates to this research regarding whether some Responsible Authority groups within licensing were operating as Street Level Bureaucrats. A definition of this term plus its applicability to this research is discussed.

In Chapter Four, the **methodology and methods** used to investigate the research questions are outlined. This study has two research questions, which are:

- How is national policy around the role of Public Health in alcohol licensing, translated and implemented at a local authority level?
- What are the factors that facilitate or impede Public Health engagement in alcohol licensing partnerships?

⁷ The exception to this is appeal cases, which are heard within a Magistrates court.

Following on from an iterative review of available literature, this study began with preliminary work, followed by interviews with Public Health professionals. After completion of twenty-one interviews with professionals participating in licensing work; analysis of documentation relating to licensing decisions was undertaken; and fieldwork notes from observations of Licensing Sub-Committee meetings were used to supplement and provide a check on information gathered in other ways. At the end of this Chapter a reflective account of the research is provided.

In the subsequent Chapter (Five), **Findings** from the study are provided. These findings relate to the roles that Public Health play, and could play, within licensing decisions, the engagement of Public Health within licensing partnership work and the challenges faced, and the influence of professional identity on partnerships. Findings relevant to considerations of definitions of evidence and acceptable evidence, also emerged from this research. A key issue highlighted by the research related to the impact on professional identity of the transition of Public Health departments from the National Health Service (NHS) in local authorities.

The **Discussion Chapter** (Chapter Six) elaborates on the key themes identified from the findings of this research. The importance of the policy context surrounding licensing decisions nationally is discussed. Issues identified relate to the policy context including an implementation gap between the national policy ideal and implementation at local levels, coupled with confusion over the roles that Public Health play within licensing and over the goals of licensing joint work. Both Public Health and the licensing authority work within contested spaces, where many competing priorities and professionals all vie for attention. Enabling factors and barriers to partnership work on licensing are discussed with attention given to the debate over the necessity for the establishment of a health-based licensing objective within England.

The final Chapter (Chapter Seven) provides information on **Conclusions** that can be drawn from this research. Within this section the impact on population health of having Public Health professionals involved within licensing decisions is explored. This Chapter includes a discussion of limitations of this research and makes suggestions for future research within

the changing context of Public Health involvement within licensing decisions. The Chapter concludes with potential implications for practice identified from this research.

2. Background

There is a complex picture surrounding the consumption of alcohol and alcohol policy development and implementation within the United Kingdom. The amount of alcohol consumed by the population fluctuates and amendments to alcohol policy, combine to present a constantly changing picture in the UK. Attempts at regulating the amount of alcohol consumed by the population is not a recent intervention, historically there has been a long running debate over the best ways to control individuals' consumption of alcohol to ensure that they do not drink to excess (Nicholls and Kneale, 2015).

In this Chapter, firstly, current alcohol consumption patterns in the United Kingdom will be outlined. It is important to establish this baseline, as this provides contextual information relating to the necessity for the introduction or amendment of alcohol policies designed to regulate alcohol intake, such as licensing. The geographical area that this thesis focused on was London. In the available literature on alcohol consumption, it is noted that Londoners have lower alcohol consumption rates compared to other areas within the United Kingdom. For example, fewer than half of Londoners said they drank in the previous week in a drinking habits survey and this was the lowest figure for all regions of England and Wales (ONS, 2017). This difference will be discussed in relation to whether a lower level of alcohol intake impacts on the alcohol policies applied to London.

Then the main control measures for alcohol, that are an integral part of overall alcohol policy in the United Kingdom will be set out. Within the available literature, Babor et al (2010) in a famous text on alcohol, described alcohol as 'no ordinary commodity'. Within this text, different policy interventions that aim to reduce alcohol intake and protect the health of the public were outlined. Within this Chapter however, the focus will be on two main policy intervention types, namely pricing and taxation and regulating and/or modifying the drinking environment (Babor et al, 2010). Although there are several measures for controlling alcohol, such as marketing and education, as the primary topic of this thesis is Public Health involvement in alcohol licensing, there will only be discussion on the two areas mentioned above. Licensing interventions are an example of regulating and/or modifying the drinking environment (Babor et al, 2010). Pricing and taxation, although not directly linked to licensing policy per se, is another policy intervention. It currently receives a large amount of attention

due to the introduction of a minimal unit price for alcohol in Scotland in 2018. As this thesis concentrates on alcohol policy, it can be argued that it is important to discuss policy around this area.

Attention will then turn to alcohol licensing legislation, relating this to historical legislation that continues to be relevant and outline the existing legislative framework that dictates current policy. The focus of the discussion will then shift to the increasing involvement of 'health' professionals within alcohol policy, along with providing an examination of the involvement of Public Health professionals in alcohol licensing and policy at a national level. To provide readers with an understanding of the organisations that play an influential role in both alcohol licensing and wider policy decisions across London and England, a definition of each of these professional bodies, along with a summary of their organisational remit is provided. Finally, to provide context around the involvement of Public Health within licensing decisions, a summary of key research relating to this topic is presented.

2.1 Alcohol consumption in the United Kingdom

The rate of alcohol consumption in the UK both historically and currently follows a fluctuating pattern. During the last half of the twentieth century, UK alcohol consumption increased steadily and as consumption rose, this was mirrored by an increase in problems relating to alcohol (Anderson and Baumberg, 2006). Figures from the Office of National Statistics note that "UK alcohol consumption (measured by the average number of litres of alcohol consumed per head of population) has decreased between the years of 2000 and 2015" (ONS, 2018), with latest data stating that "Self-reported weekly alcohol consumption in England has been broadly stable since 2011" (Giles and Robinson, 2018, p12). Given that consumption of alcohol per head of population doubled in the UK between 1950 and 2004 however, these consumption trends, can be suggested to have not significantly reduced overall population alcohol consumption to date. There are also a few nuances within per capita alcohol consumption figures, for example the highest reduction in heavy drinking was in people aged between 16-44 years old, whereas consumption in those aged over 45 years old remained the same and is even noted as beginning to increase (ONS, 2017). Thus, younger age groups appear to be reducing alcohol consumption, but middle aged and older groups are increasing their consumption. In addition to variations in alcohol consumption by

age group, consumption also varies by gender, social class and geographical location in the UK (PHE, 2016).

Recent research monitoring UK alcohol consumption patterns also outlined increases in the number of individuals who do not drink alcohol at all. Figures from the Office of National Statistics (ONS, p6), in 2017, reported that “In 2016, of all people 20.4% said that they did not drink alcohol”. It has been suggested that overall reductions in alcohol consumption noted in the UK, can be partially explained by increasing numbers of people who abstain from alcohol. (PHE, 2016).

Prior to outlining literature detailing alcohol related harms and to provide a balanced picture of alcohol consumption in the UK, it is important to note that the majority of alcohol consumers use alcohol without immediate harm to themselves or others. It is this group, named as ‘responsible drinkers’ (a term loaded with assumptions in relation to those who do not fall into this category) who provide the basis for the argument that current alcohol consumption patterns in the UK are in fact, not a cause for concern or intervention. As a recent PHE evidence review noted, approximately three quarters of the UK population are either abstainers or drink alcohol at a lower level of risk, leaving around a quarter of the population who are at increasing and/or at higher risk of alcohol related harm and/or alcohol dependent (PHE, 2016, p53). In addition to this, within these figures, are 17% of the population who are listed as binge drinkers and this group can cross categories, from higher and increasing risk to drinking at lower risk (PHE, 2016).

While consumption rates for alcohol fluctuate, the overall harm associated with alcohol does not appear to immediately reflect any reductions in consumption. Admissions to hospital due to alcohol increased dramatically between the years of 2004-2012 (PHE, 2016) but this rate of increase was not sustained and in 2016/2017 the number of admissions where alcohol was listed as the main reason for admission (narrow measure) was 1% lower than 2015/16 (ONS, 2018). In addition to health concerns, reports have been produced that link alcohol to a range of issues including domestic violence, assaults, counterfeit alcohol, drink driving and lost work days due to absenteeism (PHE, 2016). There are large amounts of available research documentation that outlines alcohol related harms (For example see: Brown and Foster, 2014; IAS, 2017; PHE, 2016, Babor et al, 2010). Alcohol has also been listed as a causal

factor in health inequalities (Marmot, 2010) and research has documented a social class gradient in alcohol harms, which was named as the alcohol harm paradox (Bellis et al, 2016). This refers to the fact that individuals from lower socio-economic groups experience disproportionately higher levels of alcohol related morbidity and mortality compared to individuals from more affluent areas, despite alcohol consumption being roughly comparable (Bellis et al, 2016).

Research studies have begun examining possible reasons for reductions in overall alcohol consumption. Such studies include the Institute of Alcohol Studies (2016) research into possible reasons behind the reductions in consumption being observed within younger age group. Further research is needed in this area to decipher the exact factors influencing per capita consumption of alcohol in the UK.

2.2 Alcohol consumption in London: Is London a special area?

The focus of this thesis was on the capital city of the UK, namely London. It has been suggested that London is a special area due to lower alcohol consumption levels in comparison to other areas of Britain. In 2015 the Office of National Statistics (p12), said “almost a third of adults in London (32%) said that they do not drink alcohol at all. This is considerably higher than any other region of the UK”. The exact reasons behind this statistic are not clear but the Office for National Statistics lists a potential reason as the wide ethnic mix in the population of London (ONS, 2015).

The picture around patterns of alcohol consumption and alcohol-related harm in London is complex. Although more people report being abstinent from alcohol and the numbers of alcohol related deaths is lowest within England in London (PHE, 2016), alcohol related hospital admissions continue to rise, and alcohol-related crime is higher in London than all other English regions (London Assembly, 2016). Whilst alcohol consumption reported in London is lower than other regional areas, the available literature documents a range of issues associated with alcohol consumption. It could therefore, be suggested that London is not a special area, it is merely part of a complex national picture around both alcohol consumption and the harm issues that arise from this.

In relation to alcohol policy, London does not fall into a special category regarding which alcohol policies are applicable within its boundaries. Licensing policy is mainly dictated by national legislation, with limited flexibility built in for local decision making. London as the capital city of England, is marketed as a city that is always open. In an environment where a city is always open, having a vibrant Night Time Economy, with alcohol available for consumption, is an important part of the marketing strategy for London. Before moving on to discuss potential policies for controlling the availability of alcohol, statistics on the numbers of licensing premises in the UK is provided below to provide context in relation to licensing decisions.

2.3 Licensing Statistics

Data on the number of alcohol and late-night refreshment licences held in the UK is published by the Home Office, with the latest data being released in 2017⁸. The data covers both England and Wales with a reported response rate of 99% from all local authorities (Home Office, 2017). A summary of the statistics regarding licensing in the UK in 2017 is provided below.

There is a total of 211,500 active premises licences, which represents a 1% increase since 2016.

There were 14,300 club premises certificates, representing a 3% decrease (number of 400) since 2016

- There were 689,600 personal licences, a 6% increase of 41,700 compared with 2016.
- There were 88,000 premises licensed with late night refreshment, a 0.1% decrease (number of 100) since 2016.
- There were 8,000 premises with 24-hour alcohol licences, the same as 2016.

(Source: Home Office, 2017).

Within the headline figure of 211,500 premise licences there is a division into three categories of businesses. These are named as on-trade premises, off trade premises and

⁸ <https://www.gov.uk/government/publications/alcohol-and-late-night-refreshment-licensing-england-and-wales-31-march-2017/alcohol-and-late-night-refreshment-licensing-england-and-wales-31-march-2017>

retailers permitted to sell alcohol as both on and off trade premises. An on-trade premise is only allowed to sell alcohol for consumption within that location, such as pubs, bars and restaurants, whilst off trade premises can sell alcohol for consumption elsewhere, for example off-licences, supermarkets and convenience stores. In 2017, there were 39,500 on-sales premises licenses and 54,900 off sales premises licenses, with both licence types increasing by 1% since 2016 (Home Office, 2017). The third business category consists of premises who are licensed to complete sales both on and off premises and there were 81,800 premises licences (a 1% increase from 2016) (Home Office, 2017).

Within the available literature, it was widely reported that there had been a change in the venue for alcohol consumption patterns within the UK, with more individuals choosing to consume alcohol from off trade sources in comparison to on trade premises. For example, Foster (2016) reported that two thirds of all alcohol consumed comes from the off-trade and PHE (2016, p142) commented that “most alcohol is now bought from shops and drunk at home”. In the literature it is argued that the increases in alcohol sales in the off trade had contributed to a reduction in the overall number of pubs, bars and nightclubs.

2.4 Alcohol policy: control measures and interventions

The amount of alcohol consumed is ultimately a personal decision, but this is influenced by several factors that are beyond individuals’ control (Martineau et al, 2013). These factors are alcohol policy measures and, in this section, a range of control measures, such as pricing and taxation will be outlined, before focusing on the alcohol policy control that is central to this thesis, namely licensing.

As previously mentioned, Babor et al (2010), allocated ratings to different alcohol policy strategies and interventions, concerning their effectiveness and the extent to which the policy had an evidence base provided by research. These strategies included “pricing and taxation, regulating physical availability, modifying the drinking environment, drink driving counter measures, marketing restrictions, education and persuasion, and treatment and early intervention” (Babor et al, 2010, pp243-249). In 2016, Public Health England also published an evidence review, relating to the Public Health burden of alcohol and the effectiveness and cost effectiveness of alcohol control policies. As this work included a review of alcohol control policies, it had similarities with the measures outlined by Babor et al

(2010). The PHE review included sections on policies relating to price and taxation, marketing, regulating availability, providing information and education, managing the drinking environment and brief interventions and treatment (PHE, 2016). PHE grouped the above policies into three categories, namely affordability, availability and acceptability of alcohol and it was argued that each of the control measures could be joined to create a policy mix, which once combined will reduce the harms associated with alcohol. PHE (2016, p10) stated that “the challenge for policy makers is implementing the most effective and cost-effective set of policies for the English context”.

As the primary focus of this thesis was on alcohol licensing, a decision was taken to not discuss each of these potential measures in detail. Although pricing and taxation does not directly link with licensing, brief consideration will be given to these policy measures for two reasons. The first, as previously mentioned, is that alcohol pricing is a current policy measure that is being discussed by the national government, following the recent introduction of a Minimum Unit Price (MUP) for alcohol in Scotland in May 2018. The second reason is that pricing and taxation interventions are policy interventions, which national Public Health agencies petition the government over. The pricing and taxation of alcohol are national measures affecting the UK population of alcohol consumers. The remit of Public Health departments is to improve population health; therefore, Public Health professionals have been interested in this area due to the potential impact this would have on population alcohol consumption.

2.4.1 Pricing and Taxation of Alcohol

There are three key procedures that affect pricing, and these are “taxation, banning the practice of selling alcohol below cost or the introduction of a minimum unit price for alcohol” (Banerjee et al, 2010, p1). Specifically, in relation to taxation, this is a mechanism that may vary annually, depending upon government budget announcements (PHE, 2016). It is therefore a mechanism of control which national Public Health agencies can only influence by campaigning for tax increases on alcohol. Babor et al (2010, p242) discussed the effectiveness of taxation by stating that “effectiveness depends on government oversight and control of the total alcohol supply”. Whilst PHE argued that “policies that reduce the affordability of alcohol are the most effective and cost effective, approaches to prevention

and health improvement. For example, an increase in taxation leads to an increase in government revenue and substantial health and social returns” (2016, p7). At a national level, support for increased taxation as a measure to regulate population alcohol consumption from Public Health organisations appears high (see PHE, 2016).

Pricing interventions and specifically a Minimum Unit Price (MUP) for alcohol have received increasing attention since the publication of the Government Alcohol Strategy in 2012 (Home Office, 2012), promised the introduction of an alcohol MUP. This policy was then retracted in England but continued to be debated and campaigned for by national Public Health groups. For example, a recent debate was held in parliament over the potential for the introduction of an alcohol MUP in England. The PHE (2016, p7) evidence review also discussed a MUP for alcohol. Within this report it was stated “Implementing a MUP ensures tax increases are passed on to the consumer and improves the health of the heaviest drinkers. The MUP price measure has a negligible impact on moderate drinkers and the on-trade”. In Scotland after a lengthy legal battle a MUP for alcohol has finally been introduced and despite debate in the English parliament, the government are awaiting to see the impact of the introduction of MUP in Scotland, prior to implementing any changes in England.

Although MUP was not introduced in England, as promised a ban on ‘below cost sales’ was introduced in 2013. Research from Sheffield University which modelled the impact of this concluded that only “0.7% of all alcohol sales across the UK would be affected” (Brennan et al, 2014, p4). It has therefore been suggested that a ban on below cost sales will have little impact on per capita alcohol consumption. This view was also supported by PHE (2016, pp7-8) who argued that “bans on the sale of alcohol below the cost of taxation do not impact on Public Health in their current form”.

While nationally Public Health bodies and alcohol organisations continue to argue for the introduction of a Minimum Unit Price and increased taxation on alcohol, at the moment the main universal control mechanism for the availability of alcohol control is through licensing.

2.4.2 Alcohol Licensing

The licensing and regulation of alcohol is not a new concept and controls on the availability of alcohol through licensing have existed for centuries (Nicholls, 2012). Although not a new

concept, the level of control over alcohol availability contained within licensing legislation fluctuates between tight control to a more liberal approach (Light, 2010). Light (2010) proposed that during the 1960's in the UK a soft approach was taken within licensing which continued until the introduction of the most recent piece of legislation, namely the Licensing Act (2003), which was came into force in 2005. Light (2010) also pointed out that during times of an increasingly looser approach to licensing, population alcohol consumption rates increased.

Several legislative acts relating to alcohol licensing have been passed and subsequently altered by successive governments. It is not intended to discuss each of these separate historical measures in detail. Instead the most impactful and recent legislation, implemented since the end of the twentieth century is outlined within this thesis.

2.4.3 Removal of the need/demand criteria

In 1999, six years before the introduction of the current Licensing Act (2003) in 2005, criteria which stated that all applications for alcohol licences must be able to demonstrate a 'need' and/or a 'demand' for a new alcohol licence in a particular area were removed (Light, 2010). The removal of this condition meant that licensing committees could no longer refuse applications on the basis that there was no need or demand for an additional alcohol venue in a locality (Light and Heenan, 2009). This criterion had been introduced to prevent the clustering of alcohol premises in one area following complaints that concentrations of premises, particularly in town centres had led to an increase in crime and disorder in the Night Time Economy (NTE) (Light, 2010). Within the available literature, it was suggested that although the need and/or demand criteria was removed, the subsequent introduction of policies targeting over provision, such as Cumulative Impact Policies (CIPs) was in effect a replacement for the removal of the need/demand criteria (Light, 2010).

2.4.4 Licensing Act (2003)

The Licensing Act of 2003⁹, which actually came into force in 2005, is the current legislation covering alcohol licensing within the UK. It is supported by a guidance document, which is updated every few years, known as 'Guidance issued under Section 182 of the Licensing Act' (often shortened to the Section 182 guidance by licensing professionals) (Home Office, 2018).

⁹ http://www.legislation.gov.uk/ukpga/2003/17/pdfs/ukpga_20030017_en.pdf

The Licensing Sub-Committee and licensing authority representatives use the Section 182 guidance during sub-committee meetings as a reference document to assist with decision making.

The Licensing Act (2003) introduced four licensing objectives, under which all applications for alcohol licenses are assessed. These are:

The prevention of crime and disorder

- The prevention of public nuisance
- Public safety; and
- The protection of children from harm

(Source: Home Office, 2018)

In Scotland, there is a fifth licensing objective with the title of:

- Protecting and improving Public Health

Within the available literature there was a large amount of discussion over the importance and necessity of England implementing a fifth health focused licensing objective. Research completed in Scotland, by Mahon and Nicholls (2014) however, raised questions over the usefulness of having a health-based licensing objective. The research concluded that whilst it was useful for Public Health professionals to have a specific health objective linking Public Health representations to licensing applications, in practice, results were mixed over whether this was helpful or not (Mahon and Nicholls, 2014). A fuller discussion around the increased involvement of Public Health within alcohol licensing follows later within this Chapter.

Returning to the Licensing Act (2003), this legislation introduced two new measures that aimed to reduce alcohol related crime and disorder. The first allowed Local Authorities (LAs) to introduce Cumulative Impact Policies (CIPs). A CIP could be established on the basis that a certain geographical area was experiencing increased alcohol related problems due to the number of licensed premises within that area (Home Office, 2018). To obtain an alcohol licence in a CIP area, the applicant had to demonstrate that the granting of the additional licence would not add to or make worse any alcohol related problems in the existing CIP area

(Home Office, 2018). The main criticism of CIPs is that they can only be introduced after problems emerge due to a high concentration of licensing premises in one area (Light, 2010). If the need/demand criteria had remained in place, this would have prevented issues in the first instance, as the application for a licence within an area with existing high numbers of premises, would not have been granted in the first place (Light, 2010).

The second measure related to High Volume Vertical Drinking (HVVD) establishments, which are premises which accommodate larger numbers of customers who have to drink standing up due to a lack of seating (Light, 2010). HVVD became a cause for concern due to factors such as “the impact of a growing dominance of chain-venues whose emphasis is on attracting a younger demographic to vertical drinking establishments and the emergence of localised no-go micro districts” (Royal Geographical Society, 2010, p10). It was suggested that HVVD establishments were associated with increased alcohol related crime and disorder. To avoid these issues, limits on admission numbers and prescribed ratios of chairs/tables to customers were necessary (Light, 2010). The policy around HVVD premises did not prove popular however and only a small number of premises implemented any of the suggested measures (Light, 2010).

The Licensing Act (2003) introduced in 2005 was the first piece of legislation that introduced the concept of alcohol being available twenty-four hours a day. It was suggested that the existing legislation, where most licensed premises closed at the same time, led to people rushing to consume large quantities of alcohol prior to closing times. It was further suggested that everyone leaving at the same time led to increased rates of crime and disorder (Light, 2010). The opposite argument was that as alcohol would be available twenty-four hours a day, people would spread out their drinking over a longer period. Alcohol harm and violence would reduce as individuals would leave licensed premises at different times (Light, 2010).

Despite the discussion around the potential of twenty-four-hour licenses the predicted change to UK drinking patterns did not occur and only a few twenty-four-hour alcohol licenses were applied for (Light, 2010). In 2017, there were 8,000 premises with twenty-four-hour alcohol licenses. This was the same figure as 2016 (Home Office, 2017). In addition to the concerns raised over potential increases in crime and disorder brought on by licensed premises being open constantly, there was a large amount of opposition to the Licensing Act

(2003) from health organisations (Hadfield, 2007, in: Hayward and Hobbs, 2007). For example, The Academy of Medical Sciences (AMS) in 2004, argued that to achieve a reduction in alcohol related harms, further enforcement was necessary around the supply of alcohol (AMS, 2004). This contrasted with the provisions outlined within the proposed Licensing Act (2003) which was suggested to represent a loosening of control over alcohol.

Herring et al (2008, p252), when commenting on the Licensing Act of 2003, stated “critics (*of the legislation*) focused on the perceived conflicts of interest between the alcohol industry and groups representing health and crime and safety priorities.” Herring et al (2008, p252) expanded on this by stating “they (*the critics*) accuse the government of allowing the alcohol industry to exert undue pressure in the lead up to the Act”. Conflicts of interest between the alcohol industry and concerns regarding the level of influence exerted by the alcohol industry within policy decisions continue to the present day. For example, issues arose during the government’s social responsibility deal, in relation to alcohol industry involvement (Knai et al, 2015; Gilmore et al, 2011) and tensions continue over funding from the alcohol industry for the organisation DrinkAware (McCambridge et al, 2013).

Herring et al (2008) examined local responses to the Licensing Act (2003) across London during the first year after implementation. This research particularly focused on issues of power within decision making. It reached a conclusion that each London borough began implementation of the legislation from a different starting point (Herring et al, 2008). Herring et al (2008) suggested the current level of involvement in licensing decisions and the size of the Night Time Economy in the local area dictated the boroughs starting point. For example, boroughs with larger NTEs, such as Westminster were already heavily involved in licensing (Herring et al, 2008).

The implementation of the Licensing Act (2003) in 2005 was followed by reports in the UK popular media using terms such as ‘booze Britain’. For example, within one article, published in the newspaper *The Telegraph* in 2007, reference was made to the relaxation of licensing laws when the current legislation was introduced in 2005, along with the use of the terms ‘booze Britain’ and ‘vomit alley’¹⁰. In response to concerns over binge drinking leading to

¹⁰ <https://www.telegraph.co.uk/news/features/3634777/The-drinking-ban-cafe-culture-or-booze-Britain.html>

alcohol related crime and disorder, legislation was applied and accompanied by the publication of policy and guidance documents which aimed to encourage sensible drinking, reduce alcohol sales to minors and decrease crime and disorder (Light, 2010). These legislative acts began to be introduced almost immediately after the Licensing Act (2003) was introduced in 2005. The legislation included:

2.4.5 Violent Crime Reduction Act (2006)

This act saw the introduction of greater penalties for underage sales of alcohol, along with drinking banning orders, where an individual could be banned from purchasing alcohol, consuming or even having alcohol in public and/or from entering certain premises.

Specifically, in relation to licensing, summary reviews of premises' licences (meaning that premises experiencing high levels of crime and disorder could now be closed without a hearing) were introduced, along with alcohol disorder zones. Premises situated within an alcohol disorder zone could now be charged by the local authority to pay for the cost of addressing alcohol related problems¹¹.

2.4.6 Policing and Crime Act (2009)

This legislation introduced an offence of being under 18 years old and 'persistently' having alcohol in public and the police were given additional powers over the removal of alcohol from members of the public. For alcohol sellers, the definition of persistently selling alcohol to young people was reduced to two sales instead of three. Mandatory conditions were introduced on alcohol licences in relation to a ban on irresponsible drinks promotions. Alcohol could no longer be directly poured into another person's mouth. Requirements to provide tap water, smaller glass measures and to use age verification policies such as Challenge 25 were also implemented because of this Act¹².

2.4.7 Crime and Security Act (2010)

This legislation announced the introduction of Early Morning Restriction Orders (EMRO) (no alcohol sales were allowed between the hours of 3 am to 6 am in areas identified to have

¹¹ <https://www.legislation.gov.uk/ukpga/2006/38/contents>

¹² <https://www.legislation.gov.uk/ukpga/2009/26/contents>

existing alcohol related problems) (Home Office, 2012). The uptake of EMROs was small however and this continues to be an underused power¹³.

By 2010, despite the implementation of three pieces of legislation, concerns over the licensing system were still evident. In response, the government launched a consultation named Rebalancing the Licensing Act (Home Office, 2010). This consultation spoke of changing the Licensing Act (2003) to give power to communities to deal with a small number of irresponsible premises and it was suggested that the current licensing processes left local authorities unable to implement measures that they wanted to (Home Office, 2010). The consultation results led to the implementation of another legislative act, which was named as the Police Reform and Social Responsibility Act (2011).

2.4.8 Police Reform and Social Responsibility Act (2011)

This Act covered five main policy areas, named as “police accountability and governance, alcohol licensing, the regulation of protests around Parliament Square, the misuse of drugs, and the issue of arrest warrants in respect of private prosecutions for universal jurisdiction offences”¹⁴. It covered a wide range of differing policy areas but within the context of this thesis only changes relating to alcohol licensing will be discussed¹⁵.

The Police Reform and Social Responsibility Act (2011) measures relating to licensing, began with the introduction of two new Responsible Authority groups (RAs), namely ‘health bodies’ and the licensing authority themselves became a Responsible Authority¹⁶ (LGA 2013). The addition of the licensing authority as a Responsible Authority, provided a dual role within decisions. The licensing authority could continue to oversee decision making in relation to licensing applications, but they could also submit a representation in response to a licence application. In practice the health body that was named as a Responsible Authority was Primary Care Trusts (PCT’s). This meant that PCT’s could now undertake the roles below within licensing decisions:

¹³ <https://www.legislation.gov.uk/ukpga/2010/17/contents>

¹⁴ <http://services.parliament.uk/bills/2010-12/policerreformandsocialresponsibility.html>

¹⁵ <https://www.legislation.gov.uk/ukpga/2010/17/contents>

¹⁶ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/98130/licensing-authorities.pdf

- Make relevant representations to the licensing authority relating to new licence applications and licence variations.
- Make requests that the licensing authority review an existing licence.
- Make representations to the licensing authority regarding the potential cumulative impact of an application in an area where there was a special policy in place regarding cumulative impact (these policies became known as Cumulative Impact Policies (CIPs) or Cumulative Impact Zones (CIZs).

(Source: LGA, 2013).

Within the provisions of the Licensing Act (2003) was a statutory requirement for local council licensing teams to consult on all licensing applications with a group of professionals called responsible Authorities (RAs). Before the addition of 'health bodies' and the licensing authority themselves as Responsible Authority's, the professional groups who were tasked with reviewing applications were:

- The police
- The local fire and rescue (Fire Brigade)
- Local enforcement agency for the Health and Safety at Work Act 1974
- Environmental Health authority
- Planning authority
- body responsible for the protection of children from harm
- local Trading Standards
- any other licensing authority in whose area part of the premises is situated (If the premises fell within the boundary of two local authority areas)

(Source: LGA, 2013)

In addition to expanding the list of Responsible Authorities to include health bodies and the licensing authority, the Police Reform and Social Responsibility Act (2011) introduced changes to licensing procedures. The first change was the removal of the 'vicinity' test. Although this concept was never completely defined within legislation, the commonly accepted meaning was that a representation would only be accepted by the licensing

authority or the Licensing Sub-Committee if it originated from an individual who worked or lived in the 'vicinity' of the premises applying for a licence. From 2011, anyone with an interest could make a representation but most commonly, it continues to only be local residents and businesses (HoL, 2017).

As previously mentioned, the Licensing Act (2003) is supported by a document known as revised Guidance issued under Section 182 of the Licensing Act (2003). This document is periodically revised with the latest version being published in April 2018. Although the removal of the vicinity test potentially allowed increased numbers of interested individuals to submit representations, the Section 182 guidance also outlined that any representations made could not be 'frivolous or vexatious'. Exact definitions of these terms were not provided within the guidance however, so there is no clarity over precisely what is implied by these words. Some local areas within London have attempted to explain these terms. For example, in Haringey within their guide to making representations it states "The licensing authority might find the representations were vexatious if they arise because of disputes between rival businesses or they might be frivolous representations if they plainly lacked seriousness"¹⁷ Whilst it could be argued that while the removal of the vicinity test aimed to open up licensing procedures to a wider audience, other measures such as a lack of clear definitions for the complex terms of frivolous and vexatious may leave barriers in place. For example, members of the public who are not aware of the terminology of frivolous or vexatious may read that representations must address the licensing objectives and thus, could be deterred from submitting representations.

The Police Reform and Social Responsibility Bill (2011) also made changes to requirements for Temporary Event Notices (TENS). Requests for a new TEN now had only to be requested between 5-9 working days prior to the first day of the event. This was in addition to a standard TEN which required an application to be received at least 10 days in advance. The duration of activity under a TEN also increased to seven days and the number of single events annually increased to 21 per calendar year. Under this new system, individuals could not only request a higher number of TENS, they also had to give less notice and the events could run for a longer duration than before (Home Office, 2012).

¹⁷ <http://www.haringey.gov.uk/business/licensing-and-regulations/licensing/guide-making-representations-licensing-act-2003>

A reduction in the review time frame for Statements of Licensing Policy (SoLPs) was introduced by the Police Reform and Social Responsibility Bill (2011). SoLPs were now required to have full review every five years (from three years previously) (Home Office, 2011). There was also a reduction in the burden of proof for licensing authorities. Prior to this legislation, licensing authorities had to demonstrate that their decisions were necessary. This was altered to 'appropriate' (Spice, 2012). All licensing decisions were still required to be relevant and relate to the four licensing objectives (Spice, 2012) but they also had to be proportionate, with any conditions imposed on the licence needing to be reasonably met and balanced around the impact they would have on the other licensing objectives (Home Office, 2012).

The Police Reform and Social Responsibility Bill (2011) re-introduced EMROs and introduced Late-Night Levies (LNLs). EMROs had been introduced by the Crime and Security Act (2010) but the Police Reform and Social Responsibility Act (2011) extended the length of time that an EMRO covered (12 am to 6 am) and lowered the threshold for the introduction of an EMRO (Home Office, 2012). EMROs proved controversial however, with the police questioning the lack of additional resources allocated to them for dealing with policing areas overnight. To date EMROs continue to remain an underused licensing measure with no implementation of this control measure currently in the UK. The bill also introduced Late Night Levies (LNLs). Any LNL introduced would apply across an entire area, for example a whole London borough. Revenue raised from an LNL would be divided between the council and the police. The Home Office reasoning behind the introduction of an LNL was suggested to be due to the increased need for policing the streets late at night resulting in additional costs to taxpayers¹⁸. To date however, LNLs has not proved popular with local authorities or been widely adopted with only "nine of the three hundred and fifty local authorities in England and Wales have introduced an LNL, while 13 other issued consultations on the introduction of an LNL but did not subsequently introduce one" (House of Lords, 2017, p116). Concerns relating to the necessity of the levy applying across a whole area and a lack of police resources appeared to be behind the lack of enthusiasm for implementing this measure.

¹⁸ <http://www.camden.gov.uk/ccm/content/business/the-police-reform-and-social-responsibility-act-how-will-it-affect-you/?page=8>

Moving away from legislation but following chronologically through changes affecting alcohol policy, in 2012 the coalition government published a national alcohol strategy, simply named “The Government’s Alcohol Strategy” (HM Government, 2012). The overriding approach of this strategy centred on the notion that many alcohol consumers were ‘sociable’ drinkers, but a minority of drinkers acted irresponsibly and caused problems (HM Government, 2012). This strategy promised, in addition to other measures, a consultation over the introduction of a MUP for alcohol along with a health-related licensing objective. To date, neither of these measures have come to fruition. Six years later, a recent development from central government was an announcement of the publication of a new national alcohol strategy, potentially by the end of 2018.

In addition to the previously mentioned legislation around alcohol policy that impacted upon licensing, there one was further Act affecting the NHS and Public Health that is relevant to this thesis. This piece of legislation saw Public Health departments transfer from the NHS to local authorities. This potentially influenced the level of involvement by Public Health departments within licensing. This legislation was the Health and Social Care Act (2012).

2.4.9 Health and Social Care Act (2012)

In 2012, the National Health Service (NHS) went through a radical transformation with the Health and Social Care Act (2012)¹⁹. This brought a substantial reorganisation of the NHS. The existing health organisations of Primary Care Trusts (PCTs) were abolished and in their place Clinical Commissioning Groups (CCGs) were established. CCGs consisting mainly of General Practitioners (GPs) became the commissioners of health goods and services in local areas. A new national body, Public Health England (PHE), was established to provide strategy and Health Protection functions (Ham et al, 2015). Part of these changes saw Public Health departments transfer from the NHS, where they had been based since the 1970s, back to their historical location within local authorities.

In relation to licensing decisions, as PCTs were abolished they could no longer undertake the role of the ‘health’ responsible authority in licensing decisions as was envisaged within the Police Reform and Social Responsibility Act (2011). In practice, the role of Responsible

¹⁹ <http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted>

Authority was allocated to Directors of Public Health (DPH). As Public Health departments had relocated to local authorities, where the other Responsible Authority groups were based, there was potential for greater engagement within alcohol licensing decisions.

To ensure continuation of the new relationships between CCGs, the NHS and local authorities, new strategic boards were established in each area. These were named Health and Well Being Boards (H&WBB). These boards were a forum for discussion around the NHS transition and future plans. However, across the UK many different models of H&WBB appeared (Ham et al, 2015). Some H&WBBs formed with only a few members, whilst others evolved into a forum with a range of representatives from various professional groups (Ham et al, 2015). At a local level H&WBBs were established and at a national level, NHS England and PHE were the national bodies that would provide oversight and guidance (Ham et al, 2015).

In relation specifically to alcohol work, the National Treatment Agency (NTA) for Substance Misuse became incorporated into PHE and PHE adopted a policy guidance role around alcohol and drugs (Ham et al, 2015). Prior to 2012, in local councils and in the NHS, alcohol and drug policy and practice was the responsibility of collaborative groups, named as Drug and Alcohol Action Teams (DAATs). During the reorganisation of the NHS and the subsequent move of Public Health departments from the NHS to local authorities, DAATs also experienced changes. A few DAATs were lost completely whilst in other areas professionals from the DAAT were incorporated either into Public Health teams or Community Safety Teams (CSTs). By 2013, Public Health departments were fully involved at a local level in alcohol policy work and this represented a change in professional identity from more traditional areas of Public Health work such as infectious diseases. Superficially, it appeared that this change coincided with the transfer of Public Health from the NHS, within the available literature however this transition was suggested to relate to the culmination of a series of events dating back to the 1970s and this will be explained in further detail later in this Chapter. One final piece of relevant legislation for this research was the Policing and Crime Act of 2017.

2.4.10 Policing and Crime Act (2017)

The Policing and Crime Act (2017)²⁰ included measures that impacted on licensing decisions and these were contained within Part 7 of the Act, under changes to alcohol provisions and late-night refreshment. These changes focused on firstly, addressing the legal grey area over the period between a Licensing Sub-Committee decision to place a sanction on a licence and an applicant appealing the decision. Prior to this legislation, although a licensing committee may have decided to suspend a licence (which is referred to as an interim step), if the licence holder appealed they could continue to operate with their licence until the appeal was heard at a Magistrates court. Under this new legislation, the interim steps opted for at the review hearing were immediately instigated and remained in situ until after the appeal hearing. The list of convictions that excluded an individual from applying to become a Designated Premises Supervisor (DPS) altered, with crimes in relation to fire arms added to the list. Cumulative Impact Assessments (also known as Cumulative Impact Policies), were placed on a statutory basis, although a formal consultation was still required to be held prior to implementation of a CIP in each local area. The final change was that LNLs were now no longer required to cover an entire borough, instead coverage was only required for a subsection of an area. It was envisaged that this would encourage more areas to adopt an LNL.

All the above legislation meant that the changes had to be implemented at a local level. With the exception of the Health and Social Care Act (2012), the above legislation was all linked to crime and policing. This suggested that the legislative focus was on these areas. Working under a framework relating to crime and policing was different from the traditional roles which Public Health professionals were involved in. This raised questions in relation to how Public Health professionals became involved in work firstly in alcohol policy and subsequently licensing. The available literature on this issue is outlined in the next section.

2.5 The rise of Public Health in Alcohol work

The traditional role of Public Health work related to making improvements in population health through improved sanitation and the reduction of infectious diseases (Berridge, 2013). Berridge (2013) noted that during the first part of the twentieth century, work around alcohol was not an area that received Public Health focus. After the second world war Public

²⁰ <http://www.legislation.gov.uk/ukpga/2017/3/contents/enacted>

Health professionals started to work on chronic diseases connected to smoking, such as cancer and heart disease (Berridge, 2013). At this point a change in Public Health practice meant that Public Health teams increasingly “dealt with chronic rather than infectious disease and began to use new terminology of risk and risk factors that might bring about ill health in the distant future rather than immediately” (Berridge, 2013, p169). The importance of individual behaviours, or what became known as lifestyle factors also gained prominence but at this stage the focus remained only on smoking behaviour (Berridge, 2013).

Within 1970s literature it was argued that a shift in emphasis occurred and ‘the new Public Health model’, which had first been applied to smoking during the 1950s, began to move into the fields of drugs and alcohol (Berridge, 2013). During the 1950s, Lederman had published research which suggested the existence of a connection between per capita consumption of alcohol with levels of alcohol misuse within the population (Berridge, 2013). This proposal did not receive a large amount of attention when it was first published but in the 1970s this work became “central to what was termed as the new Public Health approach to alcohol” (Berridge, 2013, p190). This approach, which focused on population theories, was adopted by other epidemiologists who were working within Public Health (Berridge, 2013). Peterson and Lupton (1996, p4) also observed that within this new model of Public Health practice there was “a shifting away from the biomedical emphasis on the individual towards a focus on social factors, particularly ‘lifestyle’, in the aetiology of problems; a recognition of the multidimensional nature of problems and of required solutions”. Practical work relating to alcohol misuse prior to this date had primarily come under the remit of psychiatrists but in the 1970s, despite some alignment over the practical models used by Public Health and psychiatry, divisions remained in place between these professional groups (Berridge, 2013).

Berridge (2013, p195) argued that it was not until the 1980s and 90s, that the “frameworks around alcohol changed to accommodate Public Health ideas and make them a more central part of the discourse”. During the 1990s Public Health professionals were attempting to move away from a medical model, but Public Health work continued to relate to tobacco and treatment for addiction to nicotine through Nicotine Replacement Therapies (NRT) (Berridge, 2013). It was argued that by the beginning of the twenty first century, psychiatry had become less involved in alcohol work and due to the work that Public Health professionals had been completing within the treatment for tobacco addiction, Public Health became more focused

on “pharmaceutical interventions, on treatment as well as prevention and cure” (Berridge, 2013, p212).

In addition to the specific work of Public Health organisations within drugs and alcohol, a separate health coalition had formed around alcohol by the end of the 1970s. Within the literature it was argued that this group continued to “frame the terms of Public Health debate into the early twenty first century through publications such as Alcohol Policy and the Public Good (1994) and Alcohol No Ordinary Commodity” (Berridge, 2013, p225). It was suggested that this group began to lose popularity during the beginning of the twenty first century, when the focus of alcohol policy as previously mentioned became on reducing crime, disorder and binge drinking (Berridge, 2013). In 2007 however, a new group emerged, the Alcohol Health Alliance, with Professor (now Sir) Ian Gilmore, a Hepatologist and the then incumbent President of the Royal College of Physicians (2006-2010), as the chair person (Nicholls and Greenaway, 2015). Nicholls and Greenaway (2015) argue that this choice of chairperson was key as this provided the group with credibility as there was a medical professional taking a lead role in policy advocacy work. The combination of the above events placed Public Health in an ideal position to commence strategic work within the field of alcohol and drugs.

PHE continue to monitor progress made by Public Health teams in London regarding engagement within licensing. The main method used to gauge involvement by Public Health teams across London is an annual licensing survey, which is completed by the PHE London Regional Office. Reports were produced on each of these surveys and this provided useful background context for this thesis in relation to the level of involvement in licensing decisions by Public Health teams across London.

2.6 Public Health England, London Regional Office Annual Licensing Surveys

Public Health England to date, have completed two London Licensing surveys, the first during 2015 and the second in 2016²¹. As these surveys were completed with a specific focus on the London region, no substantial comparison could be attempted between Public Health involvement in licensing in London in comparison to other regions in England.

²¹ Access to this data was kindly provided by PHE, London Regional Office

The first survey completed in 2015, sought to establish a baseline of information regarding the involvement of Public Health teams within licensing processes across London. The second survey aimed to provide an update on this and specifically focused on ascertaining any increases in involvement levels and changes in practice by Public Health teams. The response rate to the survey was slightly lower in 2016 (82%) than in 2015 (94%). Both surveys asked closed questions focusing on the aims of Public Health involvement in licensing decisions, levels of engagement within licensing, areas of strength and opportunities for development.

The first group of questions on aims, showed that Public Health respondents primarily selected 'health' related reasons as their main aim. The responses most commonly given were a reduction in the burden to the NHS and ambulance service, reduction in alcohol related hospital admissions and reductions in alcohol related health harms. Although other non-health related responses were selected, such as reduction in violence and reduction in alcohol outlets, these options were chosen by a smaller number of respondents. PHE reported that there had been little change in relation to these aims during the first two years of the surveys.

The survey asked about engagement levels within licensing, with the 2016 survey describing a positive upward trend in relation to this. Levels of good or excellent engagement within licensing decisions were reported by 85% of respondents, which was an increase from 58% in 2015. No specific details were provided however, regarding the definition of good or excellent engagement. A separate question asked about the number of representations made by Public Health to licensing applications per month. In the survey this seemed to be used as a proxy measure for engagement levels as a higher number of representations per month was viewed as a sign of a good level of engagement within licensing. The 2016 survey report described a noticeable increase in representations, with only 30% of respondents not submitting any representations per month in comparison to 61% in 2015.

Part of the 2016 survey asked respondents about whether one person responded to all applications and whether this role was shared across the team. Nearly half (46%) of respondents reported that it was shared across their team. This was viewed as both positive and negative. It was positive as if a post became vacant, the rest of the team could continue to respond to applications but sharing the responsibility potentially meant that staff with

little knowledge or experience of licensing could be involved. In only 4% of areas, the Director of Public Health dealt directly with applications inferring that this role predominantly fell to more junior Public Health staff.

Under areas of strength, contribution to strategic policy was viewed as a strength and the survey reports outlined the contribution Public Health teams made to licensing policy at a strategic level. One contribution to strategy was defined as inputting into a review of the borough's SoLP, but as this is not an annual occurrence, it was commented that the number of boroughs involved in this strategic process during the period of survey completion would be low. The 2016 survey nevertheless, reported that involvement in all strategic policy work had increased since 2015 except in relation to Early Morning Restriction Orders (EMROs). It was noted that increases in strategic work related to CIPs and SoLPs (in areas where a review of the SoLP was due). The 2016 survey report emphasised that it was positive to see increases in areas of strength.

Both surveys asked respondents about their engagement with the Licensing Sub-Committee in their boroughs. The 2016 survey report stated that there had been improvements noted due to increases in the number of Public Health teams presenting representations at Licensing Sub-Committees, along with increases in the number of Public Health staff providing briefings, training and/or meeting the Licensing Sub-Committee members outside of the forum of hearings.

Opportunities for development was a sub heading used within the 2015 survey, but this had been amended to 'barriers and opportunities' within the 2016 survey report. The overall areas of concern mentioned by respondents remained similar during both years, with changes relating to the number reporting it as an ongoing concern. For example, attributing health issues to individual licensed premises was still a concern in 2016, but this was reported as less of a barrier than it had been in 2015. A similar response pattern emerged in relation to a lack of staff resources and time. Increased concern over the relevance on Public Health data in licensing decisions was expressed in 2016, in comparison to 2015 and an opportunity for development mentioned in both surveys was lack of access to data on ambulance call outs and accident and emergency assaults. The 2015 survey finished with three recommendations, one of which focused on improved data access.

As lack of access to data remained an opportunity for development in the 2016 survey report, this appears to be an unresolved issue. The remaining recommendations in the 2016 survey report spoke about providing training around Early Morning Restriction Orders (EMROs) and the Late-Night Levy (LNL). PHE had developed and trialled an analytical support package for Public Health teams involved in licensing, so a final recommendation from the latest report was to ensure that this package was widely disseminated. At the time of writing this thesis it is unknown whether this recommendation has been achieved. The licensing surveys completed by PHE provided useful background information for this research concerning the situation across London relating to Public Health involvement in licensing. The reports from the two surveys showed that some progress had been made around the involvement of Public Health professionals within licensing, but barriers remained in place that could potentially impact on engagement levels.

Prior to the introduction of legislation that saw Public Health becoming a Responsible Authority, national Public Health organisations had lobbied national government for further opportunities to become involved in alcohol policy, which included inclusion in licensing work. Across London within local areas, from personal experience, some Directors of Public Health were not initially keen on this new role within licensing. Public Health departments were already experiencing huge changes not only in their geographical location but in relation to their professional identity, brought on by leaving the NHS and entering local councils. Public Health departments initially went through a 'transition' phase, which some writers refer to as only involving a break in time to cover for the abolishment of PCTs and the establishment of CCGs, NHS England and Public Health England (PHE) (Ham et al, 2015).

Public Health teams were accustomed to NHS commissioning systems and processes but now they had to adjust quickly to local authority procedures and build new collaborations with CCGs, NHS England and PHE. Public Health staff had to adjust to working with colleagues with different professional identities to themselves, within an organisation with a different identity to the NHS. Within the NHS the focus was primarily on health-related goals but within the new system the focus moved to politics and working with local businesses to promote economic gain.

It was argued that the transfer to local councils would provide benefits to Public Health through additional opportunities for partnership working with departments such as housing, education and planning. But little was understood about the impact that these very different professional groups would have on each other and whether they could successfully work together. Public Health was required to learn new skills very quickly in order to adapt to this new environment. Within licensing decisions, ideological issues became apparent quite quickly once Public Health attempted to engage. Public Health departments are charged with promoting the health of the public at a population level. Licensing decisions however, are argued to be based on a representation on a specific licensed premise. This difference presented Public Health with a challenge in relation to the information they could submit in representations. As Mahon and Nicholls (2014, p1) argue “Public Health considerations tend to concern population level indicators and long-term trends, whereas licensing operates in an environment characterised by case-by-case decision making, negotiated settlements and complex legal argument”.

Nationally during the transition years of 2011-2013, there was a move away from government bodies dictating policy from a central location and then distributing this to local levels for implementation heralded by the Localism Act of 2011²². This policy shift became known as ‘localism’, where each area was given increased authority over decision making. From personal experience, in relation to alcohol licensing and Public Health, the policy of localism allowed each London borough to decide its ultimate level of engagement within alcohol licensing decisions. Although Public Health are Responsible Authorities, the statutory requirement rests with the licensing authority in relation to the necessity to consult with other Responsible Authority groups over licensing decisions. There are no sanctions against a Responsible Authority who does not participate in licensing.

The policy of localism developed further in some areas of England to include the devolution of budgetary power from central government to local areas. For example, the ‘Devo Manc’ project in Manchester saw the £6b budget for health and social care allocated to local areas for decisions to be made over allocations (Kenealy, 2016). London has also requested increasingly devolved powers and there are five health and social care devolution pilots in

²² <http://www.legislation.gov.uk/ukpga/2011/20/contents/enacted>

London. As previously mentioned, only one pilot in London focused on licensing and this is the London Borough of Haringey²³. As part of this pilot, Haringey envisaged gaining additional powers for the planning department and that the licensing authority could set a local minimum unit price of 50p for alcohol. The results of this pilot are however unknown.

Returning to the rise of Public Health professionals within alcohol work, the introduction of the system of Alcohol Attributable Fractions (AAFs) in 2008, could be suggested to have been an important development within the involvement of Public Health departments within alcohol policy work at local levels. This system was based on the Public Health, epidemiological term of relative risk (Jones and Bellis, 2013). The use of an epidemiological Public Health term was an indicator of a shift in emphasis of alcohol work towards Public Health Departments. As a number of alcohol related hospital admissions were now attributable to alcohol this shifted focus from individual problem drinkers towards the idea that alcohol misuse was a population wide issue that concerned everyone. Alcohol was not only badly affecting the health of a minority of the population, now most hospital admissions had a proportion of their cause related to alcohol.

An AAF allowed a calculation of the proportion of cases of a disease or type of injury that may be attributed to the consumption of alcohol (Jones et al, 2008). For example, alcoholic gastritis is wholly caused by alcohol and has an AAF value of 1 but hypertension, may only be partially caused by alcohol and therefore the AAF value allocated is a proportion of 1 (Jones et al, 2008). The application of the system of AAFs, lead to the identification of 20 conditions that were deemed as wholly caused by alcohol, such as alcoholic liver disease and 32 conditions deemed as partially attributable to alcohol (Jones and Bellis, 2013). The partially attributable conditions were further sub-divided into acute conditions, for example assaults, and chronic conditions, for example hypertension (Jones and Bellis, 2013). Each admission was allocated either the number one (if the condition was completely caused by alcohol) or a proportion of one, based on how much the condition was assessed to have been caused by alcohol (Jones and Bellis, 2013). AAFs were then used to calculate figures for all alcohol related hospital admissions across the UK. Local areas began to use alcohol related hospital admissions and additional alcohol related data from a website called, Local Alcohol Profiles

²³ <https://www.london.gov.uk/what-we-do/health/london-health-and-care-devolution/health-and-care-devolution-prevention-haringey>

for England (LAPE) as primary data sources for arguments that there was excessive alcohol consumption in their local areas. LAPE produced data sets such as years of life lost due to alcohol and alcohol related traffic accidents (LAPE, 2017). Public Health data on alcohol related health conditions was now widely available for Public Health professionals.

The system of AAFs was complex however and it was not easily understood by individuals external to Public Health, who were not aware of the epidemiological concept of relative risk. The system of AAFs also received criticism. For example, the AAF for hypertension was generically applied to all cases of hypertension in each area and not only limited to patients with alcohol related hypertension. In an acknowledgement of the methodological limitations, the system of AAFs was reviewed in 2013 (Jones and Bellis, 2013) and subsequently a 'narrow' and a 'broad' measure of alcohol related hospital admissions was introduced. Under the narrow measure only conditions wholly attributable to alcohol were included in the calculation, which substantially reduced the calculated number of overall alcohol related hospital admissions in each area. The latest data from LAPE (2018), reported that in 2016/2017, there were 1.14 million hospital admissions where the primary or any secondary reason for admission was linked to alcohol (broad measure) but admissions deemed to be completely attributable to alcohol (narrow measure), fell by 1.6% in England (LAPE, 2018)²⁴.

In 2017, LAPE added eight new indicators which measured alcohol sales and consumption, with two indicators being useful within licensing decisions, namely off trade sales of alcohol per head of population and the density of licensed premises per km² (LAPE, 2017). It could be argued that the addition of new indicators relating to licensing decisions (that would also be useful for arguments relating to cumulative impact policies), could be taken as a further indication of the rise of Public Health within alcohol policy work and alcohol licensing. Since the reorganisation of the NHS, which saw the establishment of PHE and the incorporation of the National Treatment Agency (NTA) for substance misuse into PHE, a dedicated team work around alcohol and drug policy and treatment within PHE and there is a dedicated member of staff tasked with work around alcohol licensing. PHE and the Local Government Association had previously stated that they were keen that Public Health departments

²⁴ <https://fingertips.phe.org.uk/profile/local-alcohol-profiles/data#page/0>

“maximise the impact of Public Health within local licensing regimes” (PHE and LGA, 2014, p4).

In summary, the appointment of health bodies as responsible authorities, was an example of the greater involvement of health bodies in alcohol policy. When Public Health were appointed as Responsible Authorities and could contribute to licensing decisions, there were large organisational changes and austerity measures occurring within their working environments. Public Health professionals in addition, had no experience of working around licensing and were not aware of licensing procedures.

2.7 Organisations involved in Alcohol Policy in London and England

During this Chapter reference has been made to many national and regional organisations that are involved in alcohol policy work. To provide clarity, a list of these groups along with a short outline of each organisation’s role is provided below. An outline of every group was not included with this thesis. Instead only organisations involved in alcohol licensing decisions in London have been selected for inclusion. The remit of these organisations may not only be licensing. Some organisations are statutory, whilst others are voluntary and social enterprises.

1) Public Health England (PHE) – is an executive agency of the Department of Health, and PHE was established in April 2013²⁵. Its remit is to protect and improve the nation’s health and wellbeing and to reduce health inequalities. PHE released a comprehensive evidence review of the burden of alcohol on the health of the public in 2016 (PHE, 2016) and the National Treatment Agency for drugs and alcohol was incorporated into PHE in 2013.

2) Safe Sociable London Partnership (SSLP) – Is a social consultancy that grew from the now disbanded, London Health Improvement Board and the Department of Health regional alcohol and tobacco improvement programme²⁶. SSLP offer support around licensing, guidance for Public Health teams alongside project management services and advice.

²⁵ <https://www.gov.uk/government/organisations/public-health-england/about>

²⁶ <https://www.safesociable.com/our-workoffer/>

3) The Home Office – The Home Office website states that its role relates to the security and economic prosperity of the United Kingdom²⁷. They are responsible for shaping alcohol strategy, policy and licensing conditions. The Home Office, and especially their Alcohol Policy Team, produces guidance documents which are aimed at assisting Public Health teams to become involved in licensing. For example, see Home Office Alcohol Policy Team (2012) document entitled “Additional Guidance for Health Bodies on exercising new functions under the Licensing Act 2003”.

4) Department of Health (DoH) (Now Department of Health and Social Care) – The DoH states that its role is to help people to live better for longer²⁸. The DoH leads, shapes and funds health and social care in England. It is a ministerial department supported by 27 agencies and public bodies. In relation to alcohol policy the Department of Health works with different bodies around policy development and funds projects aimed at improving health.

5) Department of Culture, Media and Sport (DCMS) – The role of the DCMS, in so far as is relevant for this thesis, is around regulated entertainment such as plays, live music and sporting events (the responsibility for licensing and late-night refreshment was transferred back to the Home Office in 2010)²⁹. So, the DCMS has a role in alcohol licensing but less prominently than the Home Office.

6) House of Lords³⁰ (HoL) – The House of Lords is relevant to this thesis due to the establishment of a select committee who completed a review of the Licensing Act (2003) in 2017. This review undertook evidence gathering over a six-month period. A final report was produced and debated in the Houses of Parliament.

7) HM Government – The government is responsible for developing and implementing alcohol strategy and policy, which includes licensing. The last national alcohol strategy was published in 2012 (HM Government, 2012). A new strategy is expected to be produced shortly.

²⁷ <https://www.gov.uk/government/organisations/home-office>

²⁸ <https://www.gov.uk/government/organisations/department-of-health-and-social-care>

²⁹ <https://www.gov.uk/government/organisations/department-for-digital-culture-media-sport>

³⁰ <https://www.parliament.uk/business/lords/whos-in-the-house-of-lords/>

8) Institute of Licensing (IoL) - is a professional group with charitable status, representing the interests of individuals who work within the field of licensing. Their website outlines a role around training and suggests that they represent members' views in the framing, reviewing and enforcement of relevant laws and regulations³¹.

9) Greater London Authority (GLA) - supports work aimed at improving the public's relationship with alcohol and reducing the negative impact it has on London and on communities³². This has included work to support local licensing teams and to enhance the role of Public Health. The GLA appointed a Night Czar in November 2016 to champion the Night Time Economy in London and work with the Mayor of London. A Night Time Commission has also been established³³.

2.8 Key Publications review

In addition to looking at legislative acts that linked with licensing, literature reviewed included key publications that examined various aspects of Public Health involvement in licensing. At the beginning of this PhD, very few studies on Public Health and licensing had been completed and published. The researcher was directed to additional key publications by informants. Please note that some of the studies were published after fieldwork had been completed on this study but as the review of literature was iterative and continual, studies published in 2018 are included in the table below.

Table 1: Key Publications

Author	Title	Publication details
Martineau F. P. et al (2013)	Responsibility without legal authority: Tackling alcohol-related health harms through licensing and planning policy in local government	Journal of Public Health, United Kingdom
Summary:		

³¹ <https://www.instituteoflicensing.org/>

³² <https://www.london.gov.uk/what-we-do>

³³ <https://www.london.gov.uk/what-we-do/arts-and-culture/mayors-cultural-vision/london-night-time-commission>

The work by Martineau et al involved a review of available literature on current alcohol control legislation in England and Wales to find barriers and opportunities for the implementation of population level health interventions. Case studies of local alcohol control policies were also described within the paper.

The main points extracted from this paper were that:

- Martineau and colleagues argued that interventions to address alcohol related health harms by licensing interventions, faced a barrier relating to the lack of a health-based licensing objective.
- An additional obstacle related to differences between Public Health compared to other responsible authorities' assessment of the relevance of health evidence to a specific licensed premise.
- It was suggested that local government could overcome these barriers by developing local evidence of health harm from alcohol, by using the Statement of Licensing Policy as a method for beginning discussions with partners over cumulative impact assessments and through partnership working.
- It was argued that developing local initiatives could be used as test cases within legal settings as that could lead to adoption at a national level.

Limitations:

- It was a literature review, so the work was not based on practical experiences of engaging within licensing.
- It was written soon after Public Health became responsible authorities so as time progressed, new developments emerged.
- This research primarily looked at legislation, without consideration of other ways of working.

Author	Title	Publication details
Mahon L. & Nicholls, J, (2014)	Using licensing to protect Public Health: From evidence to practice	Alcohol Research UK and Alcohol Focus Scotland

		Publication, United Kingdom.
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Summary:

This report was produced after an Alcohol Research UK funded project was concluded. The project itself was ran by Alcohol Focus Scotland. The licensing system in Scotland had taken a different approach to England and Wales in that Scotland has a fifth health-based licensing objective and that each area must produce an overprovision statement within their SoLP.

There were three strands to the project. The first was to hold regional licensing events in six locations across Scotland, which aimed to increase licensing partnership communication. The second was the development and dissemination of a licensing resource toolkit and finally, through dialogue sessions, it was envisaged that knowledge transfer would occur for different responsible authority groups. The licensing toolkit was produced and sent out to over 700 professionals involved in licensing. A dialogue group was set up and the information generated from this group was shared with over 800 stakeholders via a series of conferences and events.

The main points extracted from this report were:

- Despite the presence of a fifth licensing objective and the requirements around overprovision, difficulties remained in using licensing to protect Public Health.
- The project reported that the extent to which health related information is used within licensing decisions continues to be subject to different forms of interpretation by licensing boards.
- There was some evidence of a strengthening of the relationship between Public Health professionals and licensing, but it was also suggested that based on analysis of the 2013 SoLPs, only limited progress has been achieved.
- The report suggested that further work is needed in this area to understand the 2013 SoLPs and their impact on policy positions and argues that Public Health professionals should continue to use health evidence to support licensing decision making.

- This report also points to the divergence in licensing policy in different areas of the UK and suggests that it will be important to continue linking with each area to ensure implementation of a goal of using licensing to protect Public Health.

Limitations:

- Research completed in Scotland, where the licensing system is different and there is a fifth health-based licensing objective in place.
- It assumed that knowledge transfer would occur through dialogue sessions, professionals would use the licensing resource toolkit and that behaviour change would occur as a result of this.

Author	Title	Publication details
Nicholls, J. (2015)	Public Health and Alcohol Licensing in the UK: Challenges, Opportunities and Implications for Policy and Practice	Contemporary Drug Problems, United Kingdom.

Summary:

This article examined the role played by Public Health within alcohol licensing and it considered the challenges faced by Public Health. It identified issues by analysing trends in licensing practice, policy developments and key decisions and appeals. This article noted that varying levels of engagement by Public Health teams had developed in each area and this was often dependent on the leadership of the Director of Public Health or the work of local alcohol agencies to drive engagement.

The main points were:

- The difficulties within licensing and health focused on the use of Public Health data in a licensing environment that argued that population harms cannot be attributed to one specific licensed premise.
- Another area of challenge related to local government being risk averse and then was challenge from the alcohol industry.
- This article also identified that there were epistemological tensions between Public Health and licensing, relating to the perspectives adopted.
- This article also mentioned the term Street Level Bureaucracy in one paragraph about the role adopted by members of the licensing committee and their officers.
- Potential solutions to the issues were noted as being the need to establish clear and realistic goals, further research and to gain improved knowledge of the approaches to evidence, knowledge and decision making within licensing.

Limitations:

- It raised the issue of a health-based licensing objective but did not discuss how Public Health could intervene to lobby for the introduction of a fifth licensing objective.
- It was not based on the practical experiences of professionals.
- It mentioned potential solutions but did not provide specific details around how to implement these.

Author	Title	Publication details
Fitzgerald N. et al, (2017)	Implementing a Public Health Objective for Alcohol Premises Licensing in Scotland: A Qualitative Study of Strategies, Values, and Perceptions of Evidence	International Journal of Environmental Research and Public Health

Summary:

This article discussed how public health practitioners had engaged with the licensing system since the introduction of a public health licensing objective in Scotland in 2005. It was reported that interviewees felt that this objective was introduced to reduce population alcohol consumption, but this view was not always shared by other licensing stakeholders.

The main points taken from this article were:

- There is a fifth health-based licensing objective in Scotland and there are still issues around Public Health engaging in licensing partnerships.
- There are slight differences between stakeholders relating to their understanding of the goals of Public Health involvement in licensing decisions.
- Policy transfer theories provided useful insights into public health decision making in local government.

Limitations:

- The participants for this study were mostly suggested by Alcohol Focus Scotland, which could have introduced bias into the sample.
- This research focused on the fifth licensing objective and as England does not have this, the applicability of this research is limited to Scotland.
- In addition, as the main focus was on the licensing objectives and not an overview of all processes, this limits the applicability of the research to other contexts.

Author	Title	Publication details
Gavens, L et al (2017)	Processes of local alcohol policy-making in England: Does the theory of policy transfer provide useful insights into public health decision-making?	Health and Place

Summary:

This article looked at how alcohol control policies are adopted in local authorities with a focus on policy transfer. Policy transfer was defined as the knowledge about policies in one place is used in the development of policies in another time or place (Gavens et al, 2017, p: 1). It was completed through interviews and focus groups for five case study sites across England to examine stakeholder experiences of policy transfer.

The main points taken from this article were:

- There are a number of ways in which learning is shared between places
- There are factors which can assist and inhibit policy transfer, such as the historical policy context.
- Policy transfer theories provided useful insights into public health decision making in local government.

Limitations:

- Not all of the interviews were completed about policy transfer.
- It was not clear what was being shared through the policy transfer process, instead it was only apparent that this process was occurring.
- Further research was needed to identify how the model differs across England and if it applied to all Public Health departments.

Author	Title	Publication details
Fitzgerald N, et al (2018)	Democracy and Power in alcohol premises licensing: A qualitative interview study of the Scottish public health objective: Power in alcohol premises licensing.	Drug and Alcohol Review

Summary:

This article examined the experiences of public health professionals engaging in licensing decisions in Scotland. It focused on the professional's views on how power is distributed within licensing, along with restrictions in the level of influence of both public health professionals and the public, within decision making. The methods used were interviews with thirteen public health professionals.

The main points taken from this article were:

- The Public Health professionals reported that the current licensing system was unfair, and it worked against their efforts to engage.
- Professionals mentioned the quasi legal system under which licensing operated.
- The Public Health practitioners also mentioned that they felt meant that they had less resources to challenge in some cases, where for example, an applicant used a specialist lawyer to represent them at the committee.
- Public Health reported that members of the public had only a limited influence on decision making.

Limitations:

- This research was completed in Scotland, this affects its transferability to England due to different licensing systems.
- No members of the public were interviewed, therefore the conclusion that the public only had limited influence was drawn based on the opinion of the public health professionals. Further research may be necessary to gain additional information.

Author	Title	Publication details
Reynolds, J. et al (2018)	A true partner around the table? Perceptions of how to strengthen public health's contribution to the alcohol licensing process	Journal of Public Health
<p>Summary:</p> <p>This article was published in June 2018 and it discussed how little is understood about Public Health can influence alcohol decision making. The methods used were a survey followed by four focus group discussions.</p> <p>The main points were:</p> <ul style="list-style-type: none"> • The survey results showed that different areas had varying workloads, and this impacted on their ability to engage within licensing. • Public Health professionals reported a lack of status within licensing decisions. • Public Health professionals also felt that a health-based licensing objective was essential. • Solutions were seen to lie with more time to improve relationships and to adopt pragmatic approaches. <p>Limitations:</p> <ul style="list-style-type: none"> • The response rate to the survey was 64% and this research was based across London, which limits its applicability outside of this area. • This research detailed potential issues but did not raise any practical solutions beyond time for relationships to develop. 		

Whilst each of the publications above examined aspects of Public Health involvement in licensing, no study looked at the elements of policy implementation, combined with knowledge in policy and professional identity. All the studies in the table above, were completed in the UK (some from Scotland). Research from countries outside of the UK was not included due to differences in both licensing systems and measures to control the availability of alcohol. There are differences between the licensing procedures in Scotland

and England and Wales, such as the existence of a fifth Public Health based licensing objective in Scotland. The experiences in Scotland of the implementation of this objective, were viewed as relevant to England and Wales however, due to requests for the introduction of a similar objective in England and Wales.

The first paper in the table by Martineau et al (2013) was written based on a review of literature and at a time when the addition of Public Health as a Responsible Authority was still reasonably new. These factors limited the usefulness of this paper to the current study which had a focus on the practical experiences of Public Health professionals. The papers by Mahon and Nicholls (2014), Fitzgerald et al (2017) and Fitzgerald et al (2018), were based on the reported experiences of Public Health professionals in Scotland. As previously mentioned, this work is relevant to this study as it provided a partial comparison with the licensing system in England and Wales. However, the limitation remained, that the practical experiences of individuals in Scotland were not directly relevant to professionals working within London boroughs. A focus on the practical experiences of practitioners in London, is an area where this research adds to existing knowledge and provides new knowledge, especially in relation to knowledge transfer and the impact of professional identity on licensing decisions.

The paper by Nicholls (2015) was relevant to this study as it provided background context and identified gaps in existing knowledge. However, as it was a literature review and was not based on interviews with individuals involved in licensing decisions or analysis of documentation, it did not provide insight into the practical experiences of Public Health attempts to engage in the process of licensing decisions.

The paper by Gavins et al (2017), which examined alcohol policy transfer from one time or place to another, was published after the fieldwork for this study was completed. Gavins et al's research examining policy transfer is similar to one element of this research, but it differs from this research as again it did not look at practitioners' experiences and it focused purely on policy transfer. Another research paper identified as a relevant publication was by Reynolds et al (2018). Again, this study was published after the completion of fieldwork for this study. The methods used were a survey and focus groups. These methods differed from the tools used within this research. Whilst this study covered the same geographical location of London as this research and examined the practical experiences of Public Health

practitioners, it did not examine the impact of professional identity and policy implementation at local levels on licensing partnerships.

Summary:

Within this Chapter an outline has been provided of how alcohol consumption patterns in the UK fluctuate and details provided of relevant legislation and policies relating to licensing. There has been a rise in the involvement of Public Health in alcohol policy, that gradually began during the 1970s in response to the view that alcohol affected everyone and not just a minority who consumed too much. As it was argued that alcohol affected everyone, and Public Health is tasked with improving population health, there has been a subtle move towards Public Health organisations becoming increasingly involved in alcohol policy. This position was strengthened by measures such as the introduction of Alcohol Attributable Fractions for the measurement of alcohol related hospital admissions. Health bodies were added to the list of Responsible Authorities but in practice Directors of Public Health were tasked with this role. As DPHs were adjusting to their new role within licensing, changes in their working practices also occurred due to the transition from the NHS to local authorities. Public Health departments had to learn quickly and adapt to new colleagues and ways of working. In relation to decision making, there has been a shift from working within a health care system to working within a political environment.

There are several organisations involved with alcohol licensing across London who provide support and guidance to Public Health departments. The systems and procedures that have developed across London for Public Health involvement in alcohol licensing are variable. As the current process for making licensing decisions involves a range of Responsible Authority groups with varying knowledge and experience of the licensing process, for Public Health to successfully embed in alcohol licensing decisions, working in partnership with the existing, established Responsible Authorities could be argued as being crucial.

When reviewing literature that related specifically to Public Health involvement in alcohol licensing, few relevant research papers emerged. A summary of the key papers was presented to provide contextual information relating to this study. In the next Chapter, the conceptual framework and theories that surrounded this research are outlined.

3. Health policy processes and working together in partnership

In the previous Chapter, contextual information in relation to alcohol consumption patterns across the UK were provided along with licensing statistics. Examples of alcohol control measures were outlined with a specific focus on controlling alcohol availability through licensing decisions. The current legislation, namely the Licensing Act of 2003 was discussed. The Chapter provided an explanation of the reasons behind increasing involvement of Public Health professionals in alcohol policy work and, more recently, within licensing decisions. The Chapter finished with a point raised over how partnership working would be essential between the different Responsible Authority groups who were involved in licensing.

This chapter discusses the overall conceptual framework and the specific theories that guided the design of the study, the collection of data and the analysis. The research examines a particular policy shift – the move of Public Health into local authorities and the inclusion of Public Health as a responsible authority in licensing. The policies driving the shift have been outlined in the previous chapter. The study was concerned with the implementation of policy, with questions regarding how national policy was implemented at local levels and what were the facilitators and challenges to policy implementation. The overall conceptual framework draws on insights from policy science, in particular, on understandings of how the policy process works (Baggott et al, 2015; Smith and Katikireddi, 2013; Buse et al, 2012). Buse et al (2012), in common with other policy analysts, breaks down the policy process into discrete sections (while recognising that this is a heuristic device for the purposes of analysis rather than a reflection of reality). These stages typically include agenda setting (how an issue becomes seen as relevant for policy making), policy formulation, policy implementation and policy evaluation. This study was concerned with the policy implementation stage.

Within the implementation process, partnership working has emerged over recent decades as a key mechanism for ensuring that national policy can be implemented and delivered at regional or local levels. As noted earlier, public health was shifted into a new context that involved interaction within existing partnerships. Examination of partnership working as the means by which public health were expected to fulfil their role within licensing was, therefore, important to answering questions regarding the implementation process. Within

the research on partnership working, a range of explanatory theories have emerged providing insights into how and why partnerships 'work' or do not work. Three were of particular relevance for the study: the work of Buse et al (2012) on health policy processes was important for understanding the dynamics of partnership working; Freeman and Sturdy's (2015) work on knowledge within policy proved useful in looking at the role of professional background and knowledge in stakeholder interaction; and Gieryn's (1999) theory on the cultural boundaries of science which helped to explain how Public Health workers' understanding of the evidence underpinning their knowledge base and their role in licensing was a core element of their professional identity. In addition to these main frameworks, the ideas of Lipsky (1980) on Street Level Bureaucracy were useful in providing a greater understanding of the complexity of working within a local government environment and how this potentially affects the professional identity of Public Health. In the following sections, the policy science conceptual framework, partnership working as a key mechanism for policy implementation and explanatory theories outlined above are discussed in more detail.

3.1 Health Policy Process

Within the available literature the term policy was often widely used but without provision of an exact definition of this word. Buse et al (2012, p5-6) suggested that policy was "often thought of as decisions taken by those with responsibility for a given policy area" while Milio (2001, p622) described policy as "a guide to action to change what would otherwise occur, a decision about amounts and allocations of resources". If policy related to taking decisions or guiding action, then policy making appears to refer to the practical process of taking those decisions and turning them into a policy. Work by (Buse et al, 2012), provided a comprehensive outline of different theoretical models around the creation of health policy and the subsequent implementation of policy at local levels. Buse et al (2012, p1) stated that "surprisingly little guidance is available to Public Health practitioners who wish to understand how issues make their way onto policy agendas". As the focus of this research was on Public Health policy, the work of Buse et al (2012) aligned with the proposed research questions.

Buse et al (2012, p6) provided a definition of health policy as "courses of action (or inaction) that affect the set of institutions, organisations, services and funding arrangements of the health and health care system". Within the available literature these courses of action were

often separated in 'steps', with an acknowledgement that this assumes that no changes occurred to the policy during the transfer into practice (Sabatier and Jenkins-Smith, 1993).

Smith and Katikireddi (2013) wrote about theories for understanding policymaking and they suggested that the simplest accounts followed a series of steps. These authors suggested that "while the number and stages vary between models, they commonly include: problem identification; agenda setting; consideration of potential action; and evaluation" (Smith and Katikireddi, 2013, p198). Other authors selected slightly different names for each step, such as problem identification and issue recognition, policy formation, policy implementation and policy evaluation (Sabatier and Jenkins-Smith, 1993). Criticisms have been levied at stepped approaches however due to the assumption made that policy implementation is a straight forward process and the reality of what is achieved during implementation can vary from the policy ideal (Smith and Kitikireddi, 2012, Buse et al, 2012).

Applying a stepped approach to Public Health involvement in licensing decisions, leads to identification of the fact that licensing decisions were not previously incorporating 'health' related alcohol issues (problem recognition). Options to change this situation were explored (policy formation) and the course of action elected was the addition of Public Health as a Responsible Authority (policy implementation). Alternative policy options, for example, the addition of a new licensing objective focusing on health, could have been selected, but this did not occur. Whilst the first few steps appear to have been followed in relation to policy options for including health within licensing, the fourth step of policy evaluation was omitted.

According to policy analyses (or theory), steps within the policy process are completed by people labelled as 'actors', who are defined as individuals, groups or organisations (Buse et al, 2012). Within the forum of licensing, there are a range of actors involved in policy decisions, from the various Responsible Authority groups at local levels to PHE and the government at a national level. Concerning these actors involved in policy processes, Buse et al (2012) argued that it was individuals who made and implemented policy decisions, who largely determined both the contents of the policy, and ultimately people's health. It was also argued that the 'actors' were influenced by contextual factors (known as systemic factors) which were listed as "political, economic, and social, local, regional, national and international factors" (Buse et al, 2012, p11).

Work completed by Buse et al (2012) outlined a simple system for categorising policy formation and implementation, referred to as top down and bottom up. Top down approaches encompassed policy development originating from a central location, such as national government, with the completed policy being distributed to local levels for implementation (Buse et al, 2012). A bottom up approach is the opposite, where policy developed locally and grew in popularity until it was adopted by central stakeholders such as national government (Buse et al, 2012). Currently in the UK, it can be proposed that much of policy development and implementation reflects a top down approach. The addition of Public Health as a responsible authority is an example of a top-down approach, where the policy was developed within central government, with an expectation that local Public Health teams would implement the policy ideal. In some local areas across London, the policy was indeed adopted and implemented as intended but this was not universal.

Baggott (2013, p7) notes that “from the late 1990s onwards, governments redoubled their efforts to strengthen collaboration and partnership working in Public Health”. As this effort originated from central government, it could be argued that partnership working itself is another example of a top down approach to policy making that can potentially alter during implementation into local areas. Challis et al (1988) in work on policy making suggested that there were two traditions within collaboration, which was termed as optimistic and pessimistic. The optimistic approach was argued to be based on ideas of top-down, rational approaches to decision making, combined with an assumption that collaboration would be good for the public and harmony could be achieved (Challis et al, 1988). The pessimistic view disputed the idea of harmony, and instead suggested that there are differing interests within collaboration and not necessarily a desire to maximise the public good (Challis et al, 1988). Relating this to top down approaches to policy within licensing, partnership working has been encouraged within Public Health from central government, but this policy may be affected during implementation like other policies, with the approach adopted within local areas not reflecting the intentions of the policy ideal. Work centring on licensing could be argued as complicated by the interests of the various R.A. groups and the requirement to consider public good.

Whilst the majority of legislative policy on alcohol licensing continues to be a top down approach, during the time period over which this thesis was completed, a slight change

occurred in relation to the positioning of non-legislative policy development originating at regional and local levels. This was evidenced by an increased emphasis on a policy that became known as 'localism' along with health and social care devolution pilots across London, which resulted in a minority of policy formation occurring at a sub-national level.

The main criticism of top down approaches to policy was similar to the weakness identified within the step models of policy processes. It cannot be assumed that policy implementation is straight forward, and each policy may not transfer and be implemented exactly as intended at a local level (Buse et al, 2012; Hunter and Perkins, 2014; Lipsky, 1980). Buse et al (2012, p132) argued that policy implementation was "messier and more complex than even the most sophisticated top down approach could cope with". National legislation on licensing is an example of a top-down approach, but this ignores the interpretation of the policy by actors in charge of implementation at local levels (Lipsky, 1980). As Buse et al (2012) suggested, top down approaches do not consider the opinions of the actors implementing the policy. Strategic alcohol policy is also mostly developed at a national level, but it cannot be expected that this exact policy will transfer directly into practice at the local level. As Buse et al (2012, p128) comment "It cannot be assumed that a policy will be implemented as intended since decision makers typically depend on others to see their policies turned into action". Alcohol licensing policy is no different to any other policy, where potential exists for alteration during transfer and implementation into local level work practices. This gap between national policy and local level practice, caused by the policy changing between inception and implementation, was referred to within the literature as the implementation gap (Buse et al, 2012). Concerning health policy relating to Public Health involvement within alcohol licensing, part of this research examined whether there is an implementation gap between the national policy of Public Health working as a Responsible Authority and the implementation of this policy at local levels.

In addition to providing an overview of health policy processes, Buse et al (2012) also provided information on potential methods for the completion of analysis of health policy. The addition of Public Health as a Responsible Authority was introduced at the national level without an evaluation system in place to determine the impact of this policy. No evaluation in addition, was undertaken to investigate if the national policy altered during the implementation process at local levels. Buse et al (2012) argued that stakeholder analysis of

the level of support or opposition to a policy introduction and an assessment of the level of power of each stakeholder was a method for partial policy analysis. The importance of stakeholders in understanding the dynamics of policy formation and implementation was viewed as an opportunity to gain insight into problems within the policy process (Buse et al, 2012). Public Health became Responsible Authorities as part of the Police Reform and Social Responsibility Act (2011). This was national legislation and while a consultation had been held prior to the introduction of this act, there was no analysis of the positioning of key stakeholders. Relating stakeholder analysis to this study, it could be argued that if a stakeholder analysis of the addition of Public Health as a Responsible Authority had been completed, this could have assisted with both implementation of the new policy and to mitigate potential issues at local levels prior to implementation.

3.2 Partnership working: a key mechanism for policy implementation

3.2.1 Definition of partnerships and partnership working

The term partnership working was frequently mentioned within the available literature reviewed for this thesis, but precisely what this meant in specific contexts was not easy to identify. There appeared to be both the promotion of this concept as the main way of working, coupled with an assumption that professionals involved in health policy worked with partners. The exact details of how this policy was transferred into daily working practices was not defined. Within literature relating to licensing work, again an assumption was made that partnership working was the best approach to adopt, but without a specific outline of what this involved. This assumption that partnerships were a positive way of working was echoed in the literature, for example as Clarke and Glendinning (2002, p33) noted “like community, partnership is a word of obvious virtue (what sensible person would choose conflict over collaboration)”.

Despite the lack of a clear definition and terminology being ascribed to describe partnerships and partnership working, this approach has become the accepted way of working for many professions, including Public Health. As Thom et al (2012, p2) stated “Partnership working has become the accepted approach to addressing complex health and social problems which require complex solutions”. Hunter and Perkins (2014, p12) also drew attention to the fact

that a number of different terms are used in descriptions of partnerships such as “joined up working, alliance and inter-organisational relations”.

Despite the lack of clarity in relation to a universal definition of partnerships, within the literature several authors attempted to define partnership working. For example, Carnwell and Carson (2008, p5) in relation to health, social care and criminal justice partnerships, applied a definition of “a shared commitment, where all partners have a right and an obligation to participate and will be affected equally by the benefits and disadvantages arising from the partnership”. Not all partnerships however contain the elements of shared commitment, rights or obligations of participation or where participants are equally affected by the benefits and disadvantages. If this definition was applied to Public Health involvement in licensing partnerships, some Responsible Authority groups are more likely to be affected by the benefits and disadvantages of participation. For example, the licensing authority plays a more central role in licensing in comparison to the other Responsible Authority groups.

The Organisation for Economic Co-operation and Development (1990, p18) described partnerships as “systems of formalised co-operation, grounded in legally binding arrangements or informal understandings, co-operative working relationships, and mutually adopted plans among a number of institutions”. This definition is structured and outlines a system of formalised co-operation. The application of this definition to licensing partnerships was also limited as although there is a statutory basis for the involvement of all Responsible Authorities within licensing, in practice there are no legally binding arrangements in place around participation.

A different definition by Peckam (2007, pp2-3, in Thom et al, 2012, p8) suggested “partnerships are formal structures of relationships among individuals or groups, all of which are banded together for a common purpose. It is the commitment to a common cause – frequently purposive change – that characterises these partnerships”. Whilst this definition also mentioned formal structures, it appeared less rigid than the OECD definition. These different definitions of partnerships appear to be based on the actual setting within which the joint working will take place. For example, the OECD partnership definition is based on economic arrangements, Carnwell and Carson’s definition related to a health, social care and criminal justice environment and Peckam’s work related to health care.

Within the available literature, some authors expressed concern around attempts to define partnerships. Leathard (1994, p5) for example, suggested that partnerships are a “terminological quagmire” and Ling (2000, p83) wrote of a “definitional chaos” around partnership working. The term partnership working appears commonly within the available literature, but it has been suggested that it has been overused and this is causing issues. Banks (2002, p5) while writing a discussion paper for the Kings Fund, stated “the term partnerships is increasingly losing credibility, as it has become a catch-all for a wide range of concepts and a panacea for a multitude of ills. Partnerships can cover a wide spectrum of relationships and can operate at different levels, from informally taking account of other players, to having a constructive dialogue, working together on a project or service, joint commissioning and strategic alliances”.

As there is no clear universal definition of partnership, it can be proposed that this can cause confusion, for example, how do professionals allegedly working in ‘partnership’ gain an understanding of their practice and assess if they are performing well within a partnership. There is a fundamental contradiction raised by this lack of definition, as it remains a popular method of working, without a clear definition of what this actually means. Within the literature reviewed for this thesis concerning Public Health involvement in licensing decisions, there was no clear definition of partnership working. Statements such as Public Health will work in partnership with the existing Responsible Authority groups were evident, but exactly what that meant was not clearly defined.

3.2.2 The rise in a partnership working approach within health

At a global level Gallant et al (2002) (cited in Carnwell and Carson, 2008) discussed changes in partnership working arrangements during the twentieth century. Gallant et al (2002) suggested that in the 1970s, The World Health Organisation and UNICEF began raising the idea that the public should be the people who were responsible for maintaining their own health. In countries such as the UK, as previously mentioned in the work by Berridge (2013), infectious diseases were reducing to low levels and issues that impacted on health were increasing viewed as connected to individual lifestyle related choices (Gallant et al, 2002).

Health policy processes also began to move towards professionals working together in partnership. This shift towards partnership working, in conjunction with increasing emphasis

on individuals' responsibility for their health, demonstrates that partnerships are a product of wider political and socio-economic determinants, operating at both national and local levels (Geddes, 2000; Wildridge et al 2004; Zakocs and Edwards 2006; Perkins et al, 2010). Within this study, the inclusion of Public Health as a Responsible Authority was an example of a policy that was introduced based on wider political factors at the national level.

Hunter and Perkins (2014) also discussed an increase in popularity of partnerships within public policy since the 1990s. They point to a political element in this policy shift, as the increasing popularity linked to the election of the Labour government in 1997. Other authors also refer to Labour's election victory as a time when the emphasis was on "joined up solutions to joined up problems" (Glasby et al, 2011, pp2). Wildridge et al (2004, pp4-5) also commented on the year of 1997, this time in relation to an NHS white paper being published which introduced "a formal duty of partnership between the NHS, local authorities, local voluntary and not-for-profit organisations". The rising popularity of partnership approaches also led to operational changes within local government and the National Health Service (NHS). As Glendinning et al (2005a) argued, partnership approaches instigated joint planning, shared budgets and joint services, it became the term to use in policy documents and in bids.

The rise in popularity of partnership working however does not provide an explanation relating to why working in collaboration, especially within Public Health work, became viewed as the optimal approach. One concept which partially explains the rise of partnership approaches within Public Health was the term of 'wicked issues'. During the 1970s, it was suggested that Public Health issues were 'wicked issues' (Rittel and Webber, 1973). These wicked issues, for example alcohol, smoking and obesity, were argued to be difficult to address due to their complexity. Rittel and Webber (1973) argued that it would be unlikely that one professional group working alone would resolve all of the concerns around a wicked issue. Taking alcohol as an example, all issues would not be resolved by increasing treatment provision in isolation or by only increasing public knowledge through educational campaigns. The resolution of a wicked issue would involve professionals working with a range of staff and agencies such as schools, local councils, the NHS and the voluntary sector. This concept of 'wicked issues' however, can be proposed as instrumental in the adoption of partnership working to tackle Public Health issues.

The concept of wicked issues became so widely used that the Audit Commission (1998, p9) included wicked issues as one of the five main reasons for the development of a partnership approach to work. The four other reasons listed by the Audit Commission (1998) were to deliver coordinated packages of services to individuals, to reduce the impact of organisational fragmentation and minimise the impact of any perverse incentives that result from it, to bid for or gain access to new resources and to meet a statutory obligation. Whilst this is only one example of potential positive outcomes from a partnership approach and there are no negatives listed, it is difficult to argue against partnership working.

The rise in popularity of partnerships has continued and partnership working appears as a key factor in Public Health work with a range of differing partners. Hunter and Perkins (2014) suggest that the appeal of partnership working relates to the point that challenges facing Public Health cannot be resolved by one department in isolation. Within the available literature on partnership working, there is a large amount of support for this approach.

Snape and Stewart (1996, cited in Powell and Dowling, 2006, p306) identified three types of partnership and they named these as facilitating, coordinating and implementing.

- 1) Facilitating – manage entrenched, highly problematic, contentious or politically sensitive issues in which issues of power are at stake, with trust and solidarity being essential for success power issues (maybe not in the sense here).
- 2) Coordinating – focus on less contentious issues where partners agree on priorities but are equally concerned with other pressing demands specific to themselves.
- 3) Implementing – more pragmatic and time limited, concerned with specific and mutually beneficial projects.

Specifically, in relation to Public Health and dealing with so called wicked issues, it could be suggested that Public Health would ascribe to a facilitating partnership approach. Examining this in the context of this research into Public Health and alcohol licensing decisions, although Public Health may wish to use a facilitating approach, in practice the adopted partnership type appears more of a co-ordinating approach, especially in areas where involvement within licensing decisions has proved contentious.

Moving on to specifically focus on Public Health partnerships, within the literature it was argued that addressing Public Health problems involves several organisations and professional groups (Perkins et al, 2010). Hunter and Perkins (2014) subsequently argued that an assumption can be made that Public Health problems, led to complicated partnerships, which can take a long time to impact on the actual problem. As Public Health partnerships involved a wide range of professionals aiming to deal with a complex problem, it is plausible that these partnerships would not achieve a quick resolution of issues. One negative aspect of a complicated problem relates to the complexity itself, as this could prevent a full understanding of the problem and therefore the possible responses to the issue may not be apparent (Hunter and Perkins, 2014). In this scenario, this could act as a barrier to the establishment of a partnership approach and potentially the professional would be left with feelings of insecurity and inadequacy within their role. This connected with work completed by Shaw et al (1978) around role inadequacy and insecurity. Theories around this subject, first emerged during the 1970s when Shaw et al (1978) focused on the recognition of alcohol problems by General Practitioners and their failure to respond to alcohol problems. Applying this to the above example over complex problems within Public Health, it could be argued that this work is still relevant. Shaw et al (1978) suggested that non-specialists felt inadequacy within their role as they lacked the necessary information and skills to respond. In addition, non-specialists were concerned about role legitimacy, as the professionals were not sure if alcohol problems were part of their responsibilities. Lastly, non-specialists felt they lacked role support over how or whether to respond (Shaw et al, 1978). Shaw et al (1978, p131) expanded on their initial ideas by proposing that even in the situation where non-specialists were provided with general training on alcohol problems, “it was rarely accompanied by any training in how to acquire the skills necessary to translate this knowledge into practical responses”. The work of Shaw et al (1978) also links with the focus of this thesis on Public Health involvement in alcohol licensing decisions, in relation to Public Health professionals attempting to engage in partnership with the other Responsible Authorities.

Despite a lack of research into the outcomes of health partnerships and the outcomes of partnership work in general, the popularity of partnership working has continued to grow. As the use of partnership approaches across the public sector grew, professionals working

within the fields of drugs and alcohol were also encouraged to adopt this way of working. For example, the National Alcohol Harm Reduction Strategy for England spoke of “creating a partnership at both national and local levels between government, the drinks industry, health and police services, and individuals and communities to tackle alcohol misuse” (Cabinet Office, 2004, p8). When the follow up strategy, called *Safe, Sensible, Social: The next steps in the National Alcohol Strategy* was published in 2007, the terminology of partnership was frequently mentioned (Mastache et al, 2008). Thom et al (2011) point out that the popularity of joint working in the field of addictions occurred before the popularity of the term in the middle of the 1990s. Thom et al (2011, p1) noted that “despite the apparent consensus which surrounds the use of a partnership approach, we know very little about how partnerships evolved in the alcohol field or how effective they are as a method of developing and implementing local policy”. In addition to an emphasis on partnership working within Public Health, within the field of alcohol and drugs this approach has also been promoted. The popularity of partnership working within Public Health has grown to the extent that in a recent publication by the Local Government Association (2018) on standards for employers of Public Health teams, the first standard has the title of ‘partnerships and accountability’. The description of this was “the need to work in partnership to ensure the whole Public Health system works effectively” (LGA, 2018, p9).

Within the literature there were examples of partnerships that flourished, whilst other examples of partnership working involving Public Health professionals did not appear to be viewed as successfully. As Thom et al (2011, p12) noted “while partnerships around crime, licensing and community safety had seemed to forge ahead since the turn of the century, the involvement of health and Public Health was often criticized as lacking or half-hearted and partnerships around health were certainly less visible”. At this point partnerships on crime, licensing and community safety were primarily staffed by professionals from DAAT teams rather than Public Health, with Public Health professionals not engaging within alcohol or drugs work potentially as this was viewed as the main role of the DAATs. As time progressed a joint working approach continued to be promoted. For example, one of the key elements of the Alcohol Improvement Programme (AIP) was the delivery of programmes that required partnership working (Thom et al, 2012). Thom et al (2012) argue that the publication of the Government’s Alcohol Strategy in 2012 added additional importance to partnership working

through the encouragement for boards to work across local councils and the NHS, along with a requirement to complete a Joint Strategic Needs Assessment. By this point, Police and Crime Commissioners had received commissioning powers and budget to enable them to work with partners to cut crime and anti-social behaviour (Thom et al, 2012). These changes aligned professionals working within addictions with Public Health teams. Wildridge et al (2004, p3) argued that “individual partnerships operate within very specific, localised contexts. They are strongly dependent on the past relationships between the organisations involved and local requirements and circumstances”. It could be suggested that this is one possible explanation for why a universal model of partnership working does not apply across all public policy partnerships.

3.3 Enabling factors for partnership working

Whilst reviewing the available literature that centred on partnership working, it became apparent that the lack of research on the effectiveness of partnerships was matched with an abundance of research into the process of joint working and enabling factors for partnerships. Due to the large amount of research within this area, the focus within this thesis is on essential enabling factors that appeared mentioned commonly within studies. Wildridge et al (2004, p5) for example, in research which examined various other models of partnership working (not a systematic review), suggested that successful partnerships had six key elements, which were:

- 1) **Trust** is very important – sharing knowledge engenders trust
- 2) Ensuring that **smaller partners** are seen as bringing **equal value** through their local knowledge and local legitimacy
- 3) **Clear consistent communications** and including the views of service users
- 4) **Good decision making** and ensuring accountability with joint ownership of decisions adds collective accountability
- 5) **A focus on outcomes** and
- 6) **People** in place who can manage change.

The above elements all appear to align well as enablers for a partnership approach to work. Without trust, individual professionals may not be willing to share information and knowledge with one another. Trust was also mentioned by other researchers as essential in situations where there was a requirement to work across organisational boundaries

(Crawford, 1997). Gambetta (2000) also outlined the importance of trust, not only between the professionals participating in the partnership but between the organisations who were participating. Ensuring that the opinions of all partners, especially smaller organisations are viewed as equally valid as others, was suggested to be a way of ensuring that each participant felt a valued member, whilst good communication and decision making were important to ensure that the partnership progressed (Gambetta, 2000). Without notable progression, partners may lose interest in participating. Having people within the partnership with the correct level of seniority could ensure that the partnership continues to move towards achieving the goals set (Wildridge et al, 2004).

Powell and Exworthy (2001) suggested a slightly different model which grouped identified elements for partnership working under the themes of policy, process and resource.

- 1) Policy – are goals shared, are values shared and a consensus around ends and means recognised? Are there a shared vision of goals, priorities and objectives and the ordering of priorities?
- 2) Process – highlights that the mechanism to achieve goals is comprised of three elements: instruments, ownership and jointness.
- 3) Resource – human/financial resources, trust, information and the need for local champions to drive the partnership agenda forward.

The above model by Powell and Exworthy (2001) shared similar elements to those identified by Wildridge et al (2004) but within this model the issue of ensuring adequate resources was identified and instead of a focus on outcomes, the mechanism to achieve goals was suggested as important. In relation to resources, Powell and Exworthy (2001) proposed that these were not only financial and could include identifying a 'champion' to ensure the agenda of the partnership remain high profile. The identification of focusing on goals as suggested by Powell and Exworthy (2001) instead of outcomes as proposed by Wildridge et al (2004), can be argued to be interesting in relation to the earlier observation that research completed to date on partnerships rarely focuses on outcomes.

Other researchers such as Hudson et al (1999, p238) spoke of "collaborative endeavour", instead of the term partnership working. Hudson et al (1999) suggested that a successful partnership would be achieved only if the areas below were addressed:

- 1) Contextual factors – expectations and constraints
- 2) Recognition of the need to collaborate
- 3) Identification of a legitimate basis for collaboration
- 4) Assessment of collaborative capacity
- 5) Articulation of a clear sense of collaborative purpose
- 6) Building up trust from principled conduct
- 7) Ensuring wide organisational ownership
- 8) Nurturing fragile relationships
- 9) Selection of an appropriate collaborative relationship
- 10) Selection of a pathway

This approach identified areas for consideration prior to the establishment of a partnership, such as recognition of the need to collaborate and assessment of collaborative capacity (Hudson et al, 1999). This raised questions however relating to the impact upon the partnership, if these actions were undertaken prior to it being established. Like the other models considered within this Chapter, trust and involving key people were identified as important.

Research by Thom et al (2011) also examined possible options to improve partnership working, with a specific focus on alcohol policy delivery. This study identified eight actions to improve and facilitate partnership working, which were:

1. Build a tradition of partnership working: effective partnership working was more likely to exist in areas where there had been positive past experiences
2. Be flexible
3. Obtain buy in from the top and appoint champions
4. Define clear roles and responsibilities
5. Build trust
6. Break down professional silos
7. Ensure good communication
8. Demonstrate gains

Many of the actions mentioned above were shared with the other examples of models reviewed for this thesis. For example, McQuaid (2009, p16) commented “successful models

of inter-agency co-operation tend to be governed by a detailed, clearly defined strategy, a commitment to shared objectives and clear targets informed by an overarching strategic vision; a transparency of operation; and strategic interests being given priority over local or sectional interests”.

Research by the Wilder Foundation in 2001 (Mattessich et al, 2001), which reviewed studies on partnerships led to the identification of twenty factors for partnership working, which they termed as ‘critical success factors’. These were grouped under six headings and the specific factors are outlined below:

- 1) **Environment** - History of collaboration or co-operation, collaborative group seen as a legitimate leader and a favourable political and social climate.
- 2) **Membership** - Mutual respect, understanding and trust, an appropriate cross section of members, members see collaboration as in their self-interest and an ability to compromise.
- 3) **Process and structure** - Members share a stake, multiple layers of participation, flexibility, clear roles and policy guidelines, adaptability and an appropriate pace of development.
- 4) **Communication** - Open and frequent and informal relationships/communication links.
- 5) **Purpose** - Concrete, attainable goals and objectives, shared vision, unique purpose.
- 6) **Resources** - Sufficient funds, staff, materials and time and skilled leadership.

The critical success factors identified above by the Wilder Foundation (2001) are similar to the enabling factors identified within other models. With such a wide range of literature describing success criteria and elements to ensure success in partnerships, this could lead to an assumption that to achieve a successful partnership, with the various participants collaborating well together to achieve the desired outcomes, would simply involve the establishment of a partnership using the success factors. This however, is a simplistic view to adopt in relation to partnerships, with studies on the reality of partnership working identifying a gap between theory and practice and barriers to partnership working evident at times (Thom et al, 2011). In the next section, the potential barriers to collaborative working outlined in the literature are discussed.

3.4 Factors that impede partnership working

Similar to available research on facilitators for partnership working, there was a large amount of literature centring on barriers to achieving partnership working. Within this thesis it is not possible, to discuss every barrier mentioned within the literature in detail. Instead the most common impeding factors that related to alcohol licensing partnerships were identified and examined in further detail.

In practical terms, some barriers to collaborative working related to the absence of the facilitating elements. For example, trust was identified as a key element but if this was absent then it became a barrier. As Keeping and Barrett (2009, p35) commented “without trust, people may act defensively, for example, withholding information, holding up progress by failing to attend meetings or being inflexible in their approach to cross –boundary working”. Stapleton (1998) also highlighted how trust takes time to develop and its growth is dependent on acknowledgement of the effort that each group makes to the team. In relation to Public Health and alcohol licensing, Public Health have only been involved as responsible authorities for a reasonably short period of time, trust may still be being established within licensing partnerships, especially if there is no acknowledgement of positive impact that Public Health has brought to the process.

Thom et al (2011) in a previously mentioned study on partnerships delivering alcohol policy interventions, identified eight factors that could act as a barrier to partnership working and these are outlined below:

1. **Limited funding** and resources
2. **Lack of high level ‘buy in’**
3. **Failure to sustain long term commitment**
4. **Difficulty** in agreeing **shared priorities and goals**
5. Working with multiple organisations and partnerships in one area leading to **complicated lines of responsibility and accountability**
6. A lack of **institutional ‘embedding’** of the partnership
7. **Professional cultures and ‘silo’** working
8. **Poor communication** and information sharing.

Limited funding and resources along with a lack of buy in at a high level could reduce partnership working as there would be a lack of commitment to the partnership, combined with concerns over budgets. A lack of resources also increases concerns over the sustainability of the partnership over the longer term. If there are difficulties over agreeing goals for the partnership, then each partner may work towards a different goal, leading to confusion. Working towards different goals, links with communication issues and complicated lines of responsibility. Finally, if the professionals involved in the partnership only work within their own professional culture and/or silos, it is difficult to see how any meaningful joint working could be achieved.

The issues identified by Thom et al (2011) within alcohol policy partnerships are not limited only to this one type of partnership. Other researchers have identified similar issues across varying types of partnerships. McQuaid (2009, p10) for example listed some of the challenges of partnership working as “a lack of clear and/or consistent goals; resource costs; impacts on other services and differences in approaches between partners”. Mc Quaid (2009, p10), took a step further and argued that “a lack of clear, specific aims or goals is often cited as a major cause of the failure of partnerships”. Concerning, Public Health involvement in alcohol licensing, the goals of the partnership work for Public Health may not be the same as the overall licensing partnership.

In summary, the literature reviewed for this thesis concerning partnership working and the application of this to the focus of this thesis, led to the identification of a range of potential barriers. These corresponded to organisational culture and ‘silo’ approaches, professional identity and boundaries, barriers that are important in the policy implementation process and may impede the shift from policy formulation to implementation. Each of these factors will be discussed in fuller detail below.

3.5 Organisational culture and silo approaches

Glasby and Dickinson (2009) commented that defining organisational culture is not a simple task however, organisational culture can operate as both an aspiration for partnerships (to change culture) and an obstacle to partnerships (conflict rooted in culture). One definition proposed by (Schein, 2004, p 17) was that organisational culture was “a pattern of shared basic assumptions learned by a group as it solved its problems of external adaptation and

internal integration". In addition to an organisational culture, there is also each individual's professional culture. Glasby and Dickinson (2009, p11) argued in relation to health care organisations that "most organisations are composed of numerous and disparate professional cultures". This situation will also exist within licensing decisions, with both the organisational culture of the local authority and the professional identities of the various Responsible Authority groups to consider in relation to partnership working.

Wildridge et al (2004) discussed that it was common for cultural clashes to occur between people originating from different organisations who were required to work together. Public Health departments moved into local councils from the National Health Service (NHS). The NHS has a primary focus on health and healthcare, with working practices associated with medicine. Traditionally Public Health professionals at higher levels, trained in medicine prior to undertaking Public Health work and this will be discussed in greater detail within the section on professional ideology. The move of Public Health into local government required Public Health professionals to adapt to a different organisational culture than the one experienced within the NHS. For example, post transfer to local authorities, Public Health became accountable to elected members as part of their new organisational culture within local councils.

The culture surrounding Public Health practice included partnership working prior to transition into local authorities, therefore it could be argued that an additional partnership, which focused on licensing decisions, would have been easy to establish. As the addition of Public Health to the list of Responsible Authority's is a relatively recent change, few research studies have been completed on this specific area and therefore specific details on the impact of organisational and individual professional culture to date remain unknown.

One point documented in the available literature which related to Public Health departments transition into local government, was the theory that as Public Health were 'newcomers' they would have been treated as outsiders. As McGee Cooper (2005, p14) argued in relation to new professionals joining an established workforce, "the company treats new people as foreign and dangerous, the tribe closes rank to defend against new ideas and cultural differences". In addition to being new to the organisation, Public Health professionals transferred from the NHS with protections over their pay levels and benefits packages. This

meant that Public Health staff initially received greater remuneration and benefits than their new council colleagues. Glasby and Dickinson (2009) suggested that envy could be created by these circumstances and they argued that many difficulties between different professional groups arise when there is competition for resources and power.

Phillips and Green (2015, p493) described local government as a “creature of statute. It exists as a complex web of legislation created through individual acts of national parliament”. This can be argued to be a very different environment to traditional Public Health working arrangements, with a focus on improving population health. Public Health departments became employed within local councils, accountable to both the public and elected members for their decision making. For Public Health to work in partnership with the council departments it could be suggested that awareness of different viewpoints would be necessary. Phillips and Green (2015, p501) in addition, in relation to the process of decision making by council officers stated that “rather than citing a neutral discourse of evidence-based practice to justify decisions, officers draw on rather different epistemologies of practice. These were rooted in localism, empiricism and a holistic approach that arose from the need to defend decisions from the scrutiny of diverse potential stakeholders” (Phillips and Green, 2015, p501). This is an additional example of potential cultural differences experienced by Public Health professionals after their transfer into local government. After the addition of Public Health as a Responsible Authority a range of guidance documents were produced by the Home Office, Safe Sociable London Partnership (SSLP) and the Greater London Authority (GLA). All these documents mentioned working in partnership with the licensing authority and the other Responsible Authority groups and included specific steps that Public Health could take to improve licensing partnerships. Woolcock (2013) suggested that the move of Public Health to local authorities provided an opportunity for the development of a new evidence base around what worked. It could be proposed that this would have provided Public Health with an opportunity to learn a different approach to partnership working. This would also apply to joint working around alcohol licensing decisions with the other responsible authorities but given the variable engagement levels of Public Health professionals within licensing decisions across London as identified by PHE licensing surveys, this opportunity may not have been utilised to date. Nicholls (2015, p9) in a study that examined Public Health engagement within licensing stated, “there are very inconsistent

levels of engagement by area, often depending on the personal leadership of the DPHs or the work of local alcohol agencies to drive engagement forward”. This situation could imply that there are issues within partnership working around alcohol licensing decisions, with involvement levels being dependent on specific individuals or local alcohol groups.

In addition to issues that organisational and individual professional culture can present within partnership working, in the literature a tendency for individuals to adopt silo working was identified (Thom et al, 2012). Thom et al (2012) suggested that professionals were channelled into professional silos through the structures around policy delivery and this made partnership working difficult. A related concept to working in professional silos was found in research by Beatty et al (2010), which discussed the term ‘professional tribes’. If professionals only work within their own silos and/or professional tribes, partnership working across an organisation would be difficult. As licensing partnerships work with a range of professional groups, if silo working and professional tribes were evident, this would be a barrier to partnership working. McQuaid (2009, p17) stated “there must be a genuine willingness to make the partnership work, which may help to counteract the common tendencies to retreat into ‘policy silos’ based in professional disciplines or organisational structure”. Therefore, for licensing partnerships to work, it could be suggested that all partners involved would be willing to work with each other to prevent the establishment of silo working.

In addition to issues that organisational culture can raise within partnership working, the professional identity of individual practitioners can also have an influence, and this is discussed within the next section.

3.6 Professional identity and boundaries

Hall (2005, p188) suggested that each profession has its own culture which differs from other professions and includes “values, beliefs, attitudes, customs and behaviours”. Each of the responsible authority groups within licensing will therefore have their own professional culture which encompasses their professional identity. Within the literature it is argued that professional identity develops from a socialisation process, which starts during initial education and training and continues to develop through the professional’s career (Hornby and Atkins, 2000). Jelphs et al (2016, p75) commented “the process of professional training

not only passes on official learning in the sense of the technical skills with which professionals are imbued, but also serves to institutionalise professionals into certain ways of thinking and acting". Thus, for the various professionals involved in licensing, they already would have absorbed the ways of thinking and behaving within their own professional culture.

Professional identity has been described as "the attitudes, values, knowledge, beliefs and skills that are shared with others within a professional group and relates to the professional role that is being undertaken by the individual" (McGowan and Hart, 1990, cited in Adams et al, 2006). Adams et al (2006) point out that it takes time for an individual to develop their professional identity and this involves learning the skills of the profession. Masterton (2002) discussed different professional identities in relation to how this process allows the different professions to remain separate. This research, which focused on the medical professionals of doctors and nurses found that "they train separately, keep separate patient records, report to different hierarchies, read different journals and use different terminology. They have different interests, priorities, perspectives and even languages" (Masterton, 2002, p332). Although this research specifically examined doctors and nurses, it could be proposed that the same points could be applied to Public Health departments and other professionals involved within licensing partnerships.

Specifically, in relation to the professional identity of Public Health professionals, Peterson and Lupton (1996, p2) argued that Public Health departments have evolved through "a series of scientific or technical breakthroughs" that moved Public Health from a focus on sanitation and environmental issues to lifestyle factors. Peterson and Lupton (1996) refer to this as the New Public Health, but they also note that within definitions of Public Health, emphasis remains on "the use of scientific principles and on organisation and management" (Peterson and Lupton, 1996, p2). This continual reliance on scientific principles, will impact on the identity of Public Health professionals. Peterson and Lupton (1996, p6) proposed that the reliance of Public Health professionals on science is similar to medical practitioners, as both professions use science as the "bulwark of their credibility and social standing". There is a fundamental difference between medical and Public Health professionals however in relation to medicine focusing on the individual whilst Public Health's concern is with the health of the population. The move to the new Public Health model shifted the professional identity of Public Health professionals from medicine into a population wide focus on lifestyle, but

elements of the traditional link with medicine remained. Evans and Knight in 2006 (p1) in a report on the evolving roles within Public Health stated that “the last twenty years have seen a sea change in professional roles and in the practice of specialist Public Health in the UK. In the past specialist Public Health posts were restricted to those with a medical qualification”. It is important to note however that during the conclusion of their report these same authors, were unsure if the changes noticed were as dramatic as they superficially appeared. They stated that they were unsure if “the changes represented merely a slight widening of a continuing elitist medical model of Public Health practice” (Evans and Knight, 2006, p5). This discussion over professional identity, illustrated a division in relation to professional identity of Public Health practitioners, between professionals who are aligned to medicine (and qualified medical doctors) and others who identified with the influence of lifestyle factors, risk and socio-economic factors. Relating this to licensing partnerships, the professional identity of Public Health as a Responsible Authority, would be different from the other Responsible Authority groups but in addition, the Public Health professional may identify with either a medical model or the wider determinants of health model. The training, practical skills and essential qualifications required for these different roles will vary by professional group.

One further aspect of the professional identity of Public Health practitioners which appeared within the literature and has potential importance within licensing decisions was the use of evidence and evidence-based practice by Public Health teams. The term evidence is widely used within licensing despite licensing decisions not being legal decisions. For example, in a recent licensing resource pack publication an entire section focused on the use of evidence to support policy and decision making, with emphasis on how evidence underpins effective licensing practice (AFS, 2017, p10). The definition of evidence can vary dependent on professional group however and Public Health departments appear to continue to rely on a statistical evidence base for decisions (Brownson et al, 2009). This is a different approach to the other Responsible Authorities, who argue that evidence must be premises specific and Public Health cannot supply data with this level of detail. In addition to concerns relating to specificity of Public Health evidence, within the literature an additional issue is mentioned that relates to causality. As Foster (2016, p193) notes in relation to Public Health data, “the nature of the long-term trends that it deals with, almost always looks at correlations, which

do not establish causality". Research by Fitzgerald et al (2017, p10) in Scotland on the implementation of a Public Health licensing objective, found that "as a function of local government, licensing involves very different cultures of evidence to those with which Public Health professionals may be familiar".

The issue of power in partnerships was identified within the available literature as a potential inhibitor to partnership working. Research by Thom et al (2012) discussed power imbalances between professional groups and concluded "partnerships are faced with countering traditional professional hierarchies and the possible dominance of some professional groups over others" (Thom et al, 2012, p20). Relating this to Public Health and licensing, it appears that certain responsible authority groups have a greater level of involvement within decisions than others. There are some Responsible Authority groups who did not engage within licensing decisions, such as children's services. Whether this situation has arisen due to the dominance of other Responsible Authorities or power imbalances has not been investigated. McQuaid (2009) and Wildridge (2004) also mention the subject of power, especially in relation to the impact that differences in levels of power can have on a partnership.

As previously discussed in the section on enabling factors for partnership working, all partners being treated equally was identified as important. Roderiguez et al (2007) coined the phrase 'mandated collaboration' where professionals have no choice but to work in partnership as it is a mandatory requirement. The involvement of Public Health within licensing decisions, could be argued to be an example of a situation where mandated collaboration was established. Public Health are required to be consulted upon in relation to licensing applications, however this is the end of the mandated collaboration, as Public Health do not need to submit a representation or comment on each application.

During this Chapter, the literature on definitions of partnership working has been reviewed and this has demonstrated that there is no one clear definition of partnerships. Factors that work to enable partnership working were outlined along with the main potential barriers to working in partnership. The level of impact of each enabling factor or barrier to partnership working was not clear from within the literature and it could be proposed that some factors would be more difficult to address than others. For example, practitioners do not contemplate organisational and professional ideology in their everyday work practices. The

next Chapter on Methodology will outline the approaches used during this research to explore these issues in greater depth. This will add new knowledge and to existing knowledge on Public Health involvement in licensing, especially in relation to policy processes, partnership working and professional identity. These are areas that have not received a great deal of attention in the currently available published literature on Public Health engagement within licensing partnerships.

3.7 Knowledge in Policy

As this thesis examined national policy translation and implementation at the local level, work around knowledge within policy, which directly related to Public Health involvement within licensing decisions was important. Public Health were added to an existing list of Responsible Authority groups who had historically worked together around licensing decisions. As a new Responsible Authority, Public Health were required to gain both knowledge and develop practical skills relating to licensing. How Public Health achieved this became an area of focus in this research, which linked with the extraction of knowledge from policy and its application in practical settings. Within the literature the work of Freeman and Sturdy (2014) on knowledge and policy, provided a conceptual framework that assisted in answering the research questions posed. Freeman and Sturdy (2015, p201) stated that they “endeavoured to develop a phenomenology of knowledge that will be compatible with any and all epistemologies”. But whilst the work of Freeman and Sturdy (2014) did not outline varying levels of knowledge contained within policy development and implementation, it did provide insights into knowledge systems. Their work outlined the different forms that knowledge could take without looking at which individual knew which pieces of knowledge (Freeman and Sturdy, 2015). Freeman and Sturdy (2014, p4) argued “if we are to understand the role of knowledge in policy, we need to understand the role of policy in knowledge”.

The main emphasis of Freeman and Sturdy’s (2015) work was the proposal that knowledge can be categorised as embodied, inscribed and enacted. The first knowledge type, named as embodied, was defined as knowledge used daily and held inside the individual (Freeman and Sturdy, 2015). Freeman and Sturdy (2015) proposed that within the overriding category of embodied knowledge were two subsets called tacit and embrained knowledge. Tacit knowledge was described as “practical and gestural knowledge, deeply embedded in bodily

experience and incapable of expression in a verbal form” (Freeman and Sturdy, 2015, p9). The example provided within their work of tacit knowledge was the knowledge required to ride a bike (Freeman and Sturdy, 2015). Individuals either know how to ride a bike or not, and once someone could ride a bike it was difficult to explain bike riding to others (Freeman and Sturdy, 2015). Relating this to licensing, tacit knowledge would be the knowledge of how a Licensing Sub-Committee operates, without being informed of the entire procedure. The spoken version of tacit knowledge was labelled as embrained knowledge (Freeman and Sturdy, 2015). Freeman and Sturdy (2015) proposed that tacit and embrained knowledge could be combined into one category, named as embodied knowledge and this served to “direct attention to the importance of embodied human beings in the distribution, movement and mobilisation of knowledge” (Freeman and Sturdy, 2015, p9). Due to the containment of embodied knowledge (both tacit and embrained) internally, potentially this type of knowledge was difficult to share with others (Freeman and Sturdy, 2014).

As embodied knowledge exists within an individual, when the person moves this type of knowledge also travels with them, but it can also decay due to only being held by one person (Freeman and Sturdy, 2015). In relation to licensing decisions, if a professional does not keep updating themselves of changes to licensing practice, such as the revisions within the Guidance Issued under Section 182 of the Licensing Act, then they could lose embodied knowledge. Freeman and Sturdy (2015) do however suggest that embodied knowledge can be recovered by “exposure to new experiences or information” (Freeman and Sturdy, 2015, p10). Relating this part of the knowledge system to licensing decisions, it could be suggested that there must be large amounts of embodied (tacit and embrained) knowledge maintained by the different Responsible Authority groups, pertaining to their specific professional role. It could be proposed however, that the licensing authority will hold the highest levels of embodied knowledge as licensing is their main role. When Public Health professionals became Responsible Authorities, they needed to find a way of accessing this knowledge base to increase their levels of ‘know how’ and ‘know that’ (Freeman and Sturdy, 2015) within licensing.

The second category of knowledge was termed as inscribed knowledge, which was knowledge written in books and texts and this was described as the standard mechanism of policy making (Freeman and Sturdy, 2015). One advantage of gaining knowledge from this

source was that written texts can be accessed over a long-term period without any negative effects on the knowledge by external factors, such as staff turnover (Freeman and Sturdy, 2015). When Public Health became a Responsible Authority guidance documents were published to assist Public Health in engaging within licensing partnerships. In addition to these documents, events were held which provided presentations aiming at improving Public Health involvement in licensing. Although these guides provided information, they were produced at a national level, which did not consider local areas. This was an example of an implementation gap between the policy ideal and local practice. For example, the guides suggested the presentation of Public Health statistical data (such as alcohol related hospital admissions) to the Licensing Sub-Committee, but, this information proved problematic in some local areas (Foster, 2016). New guidance documents aiming to assist Public Health involvement in licensing decisions are continually being published which demonstrate a change in recommendations over the information to use, for example a document on using case law within Public Health representations has become available on the PHE website.

Concerning the use of inscribed knowledge as the standard mechanism of policy making (Freeman and Sturdy, 2015), within licensing, it is the Statement of Licensing Policy (SoLP) that outlines the approach taken by each local area. A review of the SoLP of the London boroughs who were approached to participate in this research, was undertaken for this thesis and full details of this can be seen in the Findings Chapter. A section of the review of SoLPs examined the level of Public Health information contained within each SoLP, as a proxy indicator of the level of Public Health engagement within licensing decisions within that borough. Relating this to inscribed knowledge, a greater amount of text corresponding to Public Health, could be an indication of a higher level of inscribed knowledge, relating to Public Health within that document. The SoLPs represented a source of inscribed knowledge which allowed all Responsible Authority groups to have an opportunity to “share the same ways of knowing, so forming distinctive knowledge communities” (Freeman and Sturdy, 2015, p11). It was not clear however, if a knowledge community was established within licensing and it could be proposed that for a knowledge community to develop within this arena, each group would be required to assign equal value to the inscribed knowledge contained within the SoLPs.

The main source of legislative inscribed knowledge within licensing is the Licensing Act (2003), which was implemented in 2005. Even though this is legislation, the contents of the document (inscribed knowledge) are open to individual interpretation and there is little control over how this information is “understood, interpreted and used” (Freeman and Sturdy, 2015, p205). Concerning alcohol licensing, the knowledge that Public Health professionals obtain from inscribed sources, is also open to interpretation and this is different from embodied knowledge, which as previously mentioned, affords the individual a greater level of control due to its containment internally.

Freeman and Sturdy (2015) argued that the third category of knowledge, which was named as enacted, is the point where knowledge becomes apparent. They stated that “it is only when knowledge is enacted that it acquires meaning and significance (the status as knowledge becomes apparent)” (Freeman and Sturdy, 2015, p12). Enacted knowledge therefore refers to an individual taking knowledge obtained from policy and using it in action. For example, using the context of Public Health and licensing decisions, this could be when a Public Health professional presents to a Licensing Sub-Committee meeting. In this scenario, the professional is using both embodied and inscribed knowledge, but it is only through the presentation that the knowledge becomes enacted. Freeman and Sturdy (2015) referred to this as the action phase of knowledge and suggested that current knowledge only exists for as long as it is enacted. Returning to the above example of a Public Health presentation at a Licensing Sub-Committee meeting, this did not mean that current knowledge is lost once the action phase ends. Instead, the presenter could gain new knowledge from the experience and/or retain the knowledge in a different way. As Freeman and Sturdy (2014, p214) point out “knowledge inevitably changes as it is enacted. Knowledge is therefore essentially unstable”.

Freeman and Sturdy (2015, p12) proposed that although people may possess knowledge, the enactment of that knowledge was “policed and disciplined by the communities of knowers of which they are a part”. Therefore, although Public Health may have gained knowledge about licensing, the extent to which they can enact this knowledge will remain partially controlled by the other Responsible Authorities involved in licensing decisions and to a lesser extent by other Public Health professionals who worked around licensing across London. At this point the work of Freeman and Sturdy (2014) linked with a separate body of work by Gieryn’s

(1999) on cultural boundaries of science and this work will be outlined in fuller detail later in this Chapter. The use of enacted knowledge was also suggested to be dependent on the local environment. As Freeman and Sturdy (2015, p207) commented, “enactment is often highly constrained by rules and norms, regulations and guidelines, but these exist precisely because of the essential contingency and uncertainty of enactment”. The ‘communities of knowers’ within licensing decisions, could be suggested to consist of the different Responsible Authority groups who worked within their own professional boundaries, but also within the shared environment of licensing decisions.

3.8 Cultural boundaries of science

Public Health departments transferred from the National Health Service (NHS) into local authorities as part of reforms introduced by the Health and Social Care Act (2012). Ideologically, the NHS focused on health and health care services, which was a very different organisational culture from local government. As mentioned within Chapter 2 of this thesis, the professional identity of Public Health professionals in senior roles traditionally focused on medicine and science. Although in more recent times non-medical practitioners have acquired senior positions within Public Health (it was only in 2002 that professionals without a medical background were allowed to apply for membership of the Faculty of Public Health (FPH) and thus senior positions), the dominant professional identity for Directors of Public Health continues to be medical. This is a very different professional identity in comparison to the other Responsible Authority groups involved in licensing. A commonly cited definition of Public Health is that it is “the science and art of preventing disease, prolonging life and promoting health through the organised efforts and informed choices of society, organisations, public and private, communities and individuals” (Wanless, 2004, p3). Peterson and Lupton (1996, p6) also discussed a connection between science and Public Health when they commented “Public Health and scientific medicine are traditionally archetypal modernist institutions. That is, both projects depend on ‘science’ as the bulwark of their credibility and social standing and share a similar belief in the powers of rationality and organisation to achieve progress in the fight against illness and disease”. This correlation between Public Health and science continues, despite non-medical professionals being allowed to apply for senior positions after obtaining membership with the FPH. As an example of the continual links with science, in 2016 when the Chief Medical Officer for

England recommended reducing alcohol drinking guidelines, it was argued that this change was necessary based on “scientific grounds” after “careful consideration of the scientific modelling” (DoH, 2016, p5). If, as Peterson and Lupton (1996) suggest, Public Health professionals rely on science for their credibility and social standing, it can be proposed that any changes in work that would affect their reliance on science would be resisted due to impacts on the Public Health profession.

Peterson and Lupton (1996, p8) proposed that “medical, scientific, epidemiological and social scientific knowledges are routinely employed as ‘truths’ to construct Public Health ‘problems’ and to find solutions for dealing with them. Professional expertise remains privileged over lay expertise, as is highly evidenced in health educational advice to populations on how they should regulate their lives to achieve good health”. As previously discussed in Chapter 2, the career pathway for Public Health professionals is based on gaining educational qualifications in addition to practical experience. This is not the case for the other Responsible Authority groups, who gain practical experience and therefore, arguably, lay expertise. The professional identity of each Responsible Authority group was an important consideration within this thesis, to gain an understanding of whether this would act as a factor that facilitated or impeded Public Health involvement within licensing decisions. Given the links between Public Health and science, within the literature the work of Gieryn (1999) on the cultural boundaries of science was an important area of consideration within this thesis.

Gieryn (1999, p1) proposed that the word ‘science’ often stood “metonymically for credibility, for legitimate knowledge, for reliable and useful predictions, for a trustable reality: it commands assent in public debate. If science says so, we are more often than not inclined to believe it or act upon it”. As Public Health professionals incorporate science into their professional identity, it could be assumed that Public Health will hold a view of themselves as knowledgeable, credible and trustworthy. Within licensing, the other Responsible Authority groups, will not have science as an integral part of their professional identity and therefore Public Health, could potentially stand apart from other non-scientific professionals. Public Health as scientists, may attempt to “command assent” (Gieryn, 1999, p1) within debates in relation to licensing applications and this could impede engagement with the other Responsible Authority groups.

Gieryn (1999, pp4-5) argued that “a sociological explanation for the cultural authority of science is itself ‘boundary work’: the discursive attribution of selected qualities to scientists, scientific methods, and scientific claims for the purpose of drawing a rhetorical boundary between science and some less authoritative residual non-science”. Applying this Public Health and licensing decisions if Public Health are labelled as scientists who complete scientific work, this could set Public Health apart from the other Responsible Authorities. Gieryn (1999) expanded on this idea by suggesting that even once a subject has been labelled as science, the credibility of this science is still questioned. For example, when a research study draws conclusions, other scientists will question these conclusions through the methods used or the sampling methods. Gieryn (1999) termed this as a credibility contest, which created ‘boundary work’. Gieryn (1999, p3) argued that the constant questioning could undermine the “epistemic authority of science itself” but he proposed that this did not happen as the level of belief in science is very secure. He stated, “so secure is epistemic authority of science these days, that even those who would dispute another’s scientific understanding of nature must ordinarily rely on science to muster a persuasive challenge”. Gieryn (1999, p14) claimed that “epistemic authority exists only to the extent that it is claimed by some people (typically in the name of science) but denied to others (which is exactly what boundary work does).

Gieryn (1999, p6) proposed that “the representations of science in credibility contests often takes the rhetorical form of maps” which are constantly changing and being re-drawn. While these maps are being re-drawn the boundaries of science can be moved (Gieryn, 1999). He argued that it was the edges of the boundaries which were the most contested areas, and this is where credibility contests are more likely to be held (Gieryn, 1999). Gieryn (1999, p15) suggested “the universe of such credibility contests divides into three genres, each an occasion for a different sort of boundary work”. Within licensing decisions, it could be suggested that each Responsible Authority group will maintain its own professional boundaries and at points where this overlaps with other Responsible Authority groups, are the areas where disagreement is most likely to occur.

The first category of credibility contest was termed as expulsion, which outlined a contest between rival authorities, who were all claiming to be scientific. All competitors attempted to

make claims over science and the overall aim was to place competitors who did not complete good science outside of the boundaries (Gieryn, 1999). This genre did not specifically apply to the context of Public Health involvement in alcohol licensing decisions, as not all the Responsible Authority groups would classify themselves as using scientific evidence. As each Responsible Authority group did present evidence within licensing decisions however, competition could develop focusing on which evidence carried the greatest weight. There could be elements of expulsion in addition that related to the previously mentioned divisions within the Public Health profession. Public Health practitioners experience differences in relation to those who are affiliated to medicine compared to other non-medical professionals. This scenario could be expressed as the professionals who predominantly aligned with science and medicine, attempting expulsion on professionals with a different viewpoint. Gieryn (1999) argued that within this genre, no one questioned the epistemic authority of science itself, instead the aim was to prevent people judged as not fitting to occupy that space.

The second classification was named as expansion (Gieryn, 1999). Under this boundary work, it was argued that “rival epistemic authorities square off for jurisdictional control over a contested ontological domain. Those speaking for science may wish to extend its frontiers” (Gieryn, 1999, p16). According to Gieryn (1999, p17) under this scenario the “interpretative task is not to distinguish science from (or identify it as) one of the less reliable, less trustful, less relevant sources of knowledge about natural reality”. Applying this to licensing decisions, there could be control issues in relation to the contested space within which the various Responsible Authority groups operate. The different Responsible Authorities could battle for overall control over the domain of licensing. Public Health departments began work within licensing with the label of science which was different from that of the other Responsible Authority groups and this could present a barrier to inclusion, especially if Public Health felt that they stood apart from the other Responsible Authorities.

The third and final genre was called protection of autonomy (Gieryn, 1999). Gieryn (1999, p17) argued that this was a slightly different type of boundary work, which “results from the efforts of outside powers, not to dislodge science from its place of epistemic authority, but to exploit that authority in ways that compromise the material and symbolic resources of scientists inside”. Gieryn (1999, p17) provided further clarity on this definition by stating that

this occurred when an external power such as a corporate manager tried to “make science a handmaiden to political or market ambitions, scientists put up interpretative walls to protect their professional autonomy over the selection of problems for research or standards used to judge candidate claims to knowledge”.

Relating this to this research, Public Health professionals were attempting to improve engagement within licensing decisions but if an external power, such as the head of regulatory services for example, attempted to prevent Public Health engagement then Public Health professionals may erect a barrier to protect their autonomy. For example, Public Health representations often used statistical data, such as Alcohol Attributable Fractions (AAFs), as evidence. This reliance on statistical evidence could erect a wall between Public Health and the other Responsible Authority groups who do not rely on scientific information for submissions into licensing decisions.

The use of Public Health data, such as AAFs is a complex system, which would require explanation to professionals working outside of Public Health. If Public Health are required to continually explain their systems of evidence this could reinforce their boundaries. An alternative scenario could also arise in relation to Public Health departments who were not engaging within licensing decisions and if in fact, these teams were self-excluding from licensing work to protect their autonomy. Gieryn (1999, p22) argued that “scientific knowledge and practice can be made to appear accessible and just like common sense as untutored lay people are invited to see for themselves the validity of a theory. Or, alternatively scientific knowledge and practice may become impenetrably esoteric when mapped out before seeking to impose political or ethical constraints on the unbridled search for truth”.

Gieryn (1999) suggested that the three genres and boundary contests led to situations that he named credibility contests. Within these contests “rival parties manipulated the boundaries of science to legitimate their beliefs about reality and secure for their knowledge making a provisional epistemic authority that carries with it influence, prestige and material resources” (Gieryn,1999, p237). Gieryn (1999) also argued that credibility contests created at least three social roles; the contestants who draw maps, those who rely on the maps and people affected by allocations of epistemic authority. Applying this information to this study

Public Health professionals could claim that their approach to licensing work is scientific and therefore this should carry a greater level of authority and prestige over the work of the other Responsible Authorities. But if Public Health adopted this approach, this could place them in conflict with their licensing colleagues who traditionally hold the highest level of authority within licensing decisions.

Gieryn (1999) suggested that boundary work was brought on by disputes over credibility and that his theoretical framework can also be useful for “studying contested authority in other institutional and professional’s domains (Gieryn, 1999, p34). This point provides the basis for the inclusion of Gieryn’s work within this thesis, the idea of contested authority within licensing decisions. Hall (2005) writing about boundary work claimed that it highlighted contrasts between rival professions by boosting beliefs and promoting expansion of the authority of one professional group over another. Competing professionals “labelled as frauds and scapegoats are blamed when a problem arises” (Hall, 2005, p190). Hall (2005, p190) suggested that these factors “contribute to the culture of each profession as well as to the barriers between the professionals on a team, even without their awareness”.

3.9 Street Level Bureaucracy

In addition to linking with the work of Gieryn (1999), the use of enacted knowledge (Freeman and Sturdy, 2015) also connected with work published by Lipsky (1980) around the ideas of Street Level Bureaucracy. Lipsky’s (1980) original work was updated and re-produced thirty years later in 2010, which was suggested to demonstrate the longevity of the concepts used (Lipsky, 2010). Lipsky’s (1980) original work suggested that Street Level Bureaucracies consisted of government organisations, such as Local Authorities which had the ability to make decisions relating to the public’s access to certain resources. Lipsky (1980, pxi) described Street Level Bureaucracies as “schools, police and welfare departments, lower courts, legal services offices, and other agencies whose workers interact with and have wide discretion over the dispensation of benefits or the allocation of public sanctions”. Within the context of this thesis, all the Responsible Authority groups are part of the bureaucratic organisation of local authorities and therefore fulfilled this criterion for a street level bureaucrat. In relation to licensing however, all Responsible Authority groups potentially had direct contact with the public (although in varying levels) and made decisions that potentially

impacted on access to government resources i.e. permission to hold an alcohol licence. The main Responsible Authorities who participated as Street Level Bureaucrats were the police and the licensing authority, purely due to the level of involvement of these two groups within licensing decisions. The other responsible authorities acted as Street Level Bureaucrats to varying degrees, dependent on their level of contact with the public. From personal experience, Public Health have little direct contact with members of the public in relation to licensing. Lipsky (1980, pxi) suggested that the “citizen encounters with street-level bureaucracies are not straightforward; instead, they involve complex interactions with public workers that may deeply affect the benefits and sanctions they receive”.

The original work by Lipsky (1980) made two claims, with the first relating to the fact that Street Level Bureaucrats had a high level of discretion in relation to decision making that was obtained due to a lack of resources, such as time or information (Lipsky, 1980). To cope with a busy workload Lipsky (1980, pxi) argued that Street Level Bureaucrats developed “routines of practice and psychologically simplifying their clientele and environment in ways that strongly influence the outcomes of their efforts”. This can be observed within licensing decisions in relation to the large numbers of licensing applications received in each borough. To process these applications quickly, each applicant is required to complete the same standard form, with the licensing authority being required to process each application within a specified timescale. Under the power of delegated authority, licensing professionals can decide over a licensing application without involvement of a Licensing Sub-Committee hearing. Decisions are made by individual officers which allows a high level of discretion without scrutiny.

The second claim is that different roles, such as a police officer and the licensing authority, are in fact comparable due to containing the same structures (Lipsky, 1980). It is within this point that a contradiction arises concerning “how to treat all citizens alike in their claims on government, and how at the same time to be responsive to the individual case when appropriate” (Lipsky, 1980, pxii). It was argued that Street Level Bureaucrats cannot achieve this goal and therefore they develop processes to cope with this contradiction (Lipsky, 1980). Within licensing decisions Public Health were encouraged to use a system referred to as the bullseye tool (Reynolds et al, 2018), to screen all licensing applications to ascertain if a licensing application warranted the submission of a representation. The use of this system

meant that applications are mass assessed and each individual case does not necessarily receive attention. Lipsky (2010, p xv) argued that due to this system, Street Level Bureaucrats were “caught in fundamentally tragic situations where they simply cannot put their ideals into practice, and instead lower their expectations of themselves and clients”. Gibson (2015) suggests that as per the title of Lipsky’s (2010) book, this is the dilemma of the individual in public services.

Street Level Bureaucrats were described as individuals who take national policy (such as the Licensing Act of 2003), fit this into their own ideological ideals (for example for licensing professionals, balancing the promotion of local business interests with preventing concentrations of licensed premises in one area) and then implement this policy (with their own interpretation) into local levels (Lipsky, 1980). Lipsky (1980) suggested that the coping behaviours of the Street Level Bureaucrats could increase gaps between written policy and practice (Lipsky, 1980). Due to the high level of discretion afforded to each individual, when this is combined across a department Lipsky (1980, p13) argued that Street Level Bureaucrats became policy makers. Public Health professionals, met this criterion by taking national policy on licensing, fitting this into their ideological beliefs (reducing alcohol related health harms by influencing alcohol availability) and then implementing their version of this policy. Gibson (2015, p7) pointed out that “few studies of Street Level Bureaucracy behaviour have been conducted in the health sector”, which indicates a gap in the literature in relation to this subject. With the transfer of Public Health from the health sector into local authorities, this study provided an opportunity to both add to existing knowledge and provide new knowledge in this area.

The idea that Street Level Bureaucrats become policy makers connected with the work of Buse et al (2012) on health policy in relation to top down approaches to policy implementation. As Street Level Bureaucrats have discretion that allows them to be policy makers, but they also work in front line services, the approach to policy that Street Level Bureaucrats are involved in can be argued to be bottom up (Gibson, 2015). In the literature, other authors contest the assertion that Street Level Bureaucracy is purely a bottom up approach, for example Evans (2011) argued that it is both top down and bottom up. Evans (2011), in work on Street Level Bureaucracy within a social work setting, suggested Lipsky was

concerned about how discretion was used as he was “seeing strategic policy intention as the measure of appropriate discretion” (Evans, 2011, p370).

The discretion afforded to Street Level Bureaucrats is important as it challenges both the mainly used account of public policy implementation and how to manage policy implementation to achieve policy goals and public value (Gibson, 2015). Lipsky (1980) proposed that Street Level Bureaucrats had the ability to deliver benefits and sanctions that would implement structure and potentially limit individuals lives. It was argued that each increase in benefits lead however to an increase in the level of state control and influence (Lipsky, 1980). For example, within licensing, when a new application is granted the applicant is agreeing to an increase in control over their business via monitoring and subjecting themselves to the conditions contained within the licence. Lipsky (1980) proposed that this situation positioned Street Level Bureaucrats in a role where they would face conflict (Lipsky, 1980).

Nicholls (2015) also wrote about Street Level Bureaucracy in relation to roles undertaken by licensing committees and council officers. Nicholls (2015, p11) suggested that these council employees were “required to exercise discretion when applying the law, and whose judgements are based on largely experiential knowledge, albeit within a broad legislative framework”. Nicholls argued that this approach was very different to Public Health professionals who were “more closely tied to academic measures of factual validity, professional status and institutional authority” (Nicholls, 2015, p12). Potential differences in approach by different Responsible Authority groups to licensing was an area that this research examined, and these different approaches connected to the second research question, on factors that facilitated or impeded Public Health engagement in licensing partnerships. Specifically, this study looked at different approaches of Responsible Authority groups, relating this to varying professional identities and organisational culture.

Lipsky’s (1980) work was not without criticism. Evans (2011) for example, argued that Lipsky ignored the influence of professional status within street level bureaucracies. Evans (2011) argued that professional status led to people having a commitment to service users wellbeing over economic priorities and brought in addition, an increased amount of autonomy over decision making in comparison to other Street Level Bureaucracy groups. In addition, Evans

(2011) argued that Lipsky (1980) overlooked the relationship between SLB and their line managers. This author argued that Lipsky “treated managers and professionals as categorically different and antagonistic” (Evans, 2011, p369). In research based on social workers, Evans (2011) concluded that a shared professional commitment between Street Level Bureaucrats and their line managers, fostered collaboration between these two groups which allowed them to resist pressure from higher managers to focus on budget control and performance management. Evans (2011) argued that Lipsky treated all managers as one group, who were only committed to organisational policy implementation, but this ignores the role and influence of the manager within policy. Evans (2011, p373) stated “Lipsky’s view of managers as the disinterested servants of policy, and the street level practices as the source of policy distortion is problematic”. Evans (2011, p383) criticised Lipsky for the assumption that street level workers were “not committed to organisational goals, unlike their managers”.

Summary:

Within this Chapter the main conceptual framework that impacts on this research was outlined. Buse et al’s (2012) work on health policy processes was discussed first. The main gaps in knowledge relating to licensing concern the implementation gap between national policy and policy delivery in local areas, along with a lack of clear evaluation methods for the policy that led to the addition of Public Health as a Responsible Authority. Freeman and Sturdy’s (2015) work on knowledge within policy raised issues over the extraction of knowledge from policy by Public Health professionals and how this was applied within licensing work. It also raised questions in addition that related to other Responsible Authority groups’ use of knowledge within policy. Another framework which connected to the main framework on policy processes was Gieryn’s (1999) theory on the cultural boundaries of science. This framework was relevant to an examination of the professional identity of Public Health and the other Responsible Authorities. Furthermore, in relation to the main framework – the shift from policy formation (national level) to policy implementation (local level), the ideas of Lipsky (1980) on Street Level Bureaucracy featured as a useful concept applicable to this research.

Within the next Chapter, an outline is provided of the methodology surrounding this thesis and this is followed by a detailed discussion of methods used to investigate and answer the two research questions proposed by this study.

4. Methodology

In this Chapter the methodological frameworks applied to the research design are outlined and discussed. This is followed by a detailed description of methods used to investigate the research questions and the processes followed to analyse the emerging data. In the final section, the ethical considerations and potential limitations of the study are presented.

Within the available literature, there are many different approaches available for the design of research, in general however, three main classification groups are documented, and these are named as quantitative, qualitative or mixed methods (Creswell, 2014, Bryman, 2016). The definitions of quantitative research note qualities such as “explaining phenomena by collecting numerical data that are analysed using mathematically based methods” (Aliga and Gunderson, 2000 in Muijs, 2011, p5) and “an approach for testing objective theories by examining the relationship among variables” (Creswell and Creswell, 2018). The commonality between these two definitions relates to the use of the terms ‘variables’ and ‘numerical data’, which contrasts with qualitative research, which does not necessarily involve numerical data or counting variables.

Qualitative research has been defined as “an approach for exploring and understanding the meaning individuals or groups ascribe to a social or human problem” (Creswell and Creswell, 2018, p4). Miles, Huberman and Saldana (2014, p11) also commented on the application of qualitative methods by stating “qualitative data with their emphasis on people’s lived experiences, are fundamentally well suited for locating the meanings people place on the events, processes and structures of their lives and for connecting these meanings to the social world around them”. The commonality between these quotes relates to the use of the term ‘meanings’. As this research study focused on an examination of the meanings placed on Public Health involvement within licensing decisions, a qualitative approach was selected.

This research adopted a qualitative approach which moreover was interpretivist and deductive (Bryman, 2016). It was interpretivist due to its focus on gaining understanding of the meanings informants placed on their situation, on a topic where previously only a few studies have been completed. It was also deductive as the researcher first examined the limited existing knowledge on the subject and this was used to deduce concepts for

investigation (Bryman, 2016). Whilst a quantitative (positivist) approach could have been selected, entailing the use of methods such as a survey with closed questions (Bryman, 2016), this approach would not have provided the depth of understanding required to thoroughly investigate this topic. Miles, Huberman and Saldana (2014, p4) suggested qualitative data “are a source of well-grounded, rich descriptions and explanations of human processes”. In addition to obtaining opinions from informants through in-depth interviews, this study also used fieldwork notes from observations and documentation analysis. This approach allowed the researcher to gain detailed knowledge of licensing processes as well as investigating the concepts identified.

One of the key strengths of qualitative data is the depth of understanding provided. As Miles, Huberman and Saldana (2014, p4) argue, the findings from “well analysed qualitative studies have a quality of undeniability”. Within the existing literature it was suggested that studies producing words and text have a greater impact on a reader in comparison to numerical data (Miles, Huberman and Saldana, 2014). In addition to the provision of detailed information and possessing a quality of undeniability, qualitative research has been argued to have several other ‘strengths’ (Miles, Huberman and Saldana, 2014, p11-12).

The first identified strengths connect to the environment, with the assertion that as these studies take place in a natural setting, the researcher gains a strong idea of real life, plus as data collection occurs close to the research setting, confidence in the data obtained is assured (Miles, Huberman and Saldana, 2014). A final strength mentioned within the literature and relating to the environment is that the inclusion of the local situation allows the researcher to gain knowledge on issues which may not be easily identified (Miles, Huberman and Saldana, 2014). The role of the environment within which licensing decisions are made, was an important point within this study, which was initially recognised and increasingly corroborated as an intricate element of this research.

A further strength of qualitative methods relates to the presentation of findings with in-depth and detailed descriptions of the data (Cresswell and Cresswell, 2018; Miles, Huberman and Saldana, 2014). Creswell and Creswell (2018, p200) argue that this approach “transports readers to the setting and gives the discussion an element of shared experiences”.

Miles, Huberman and Saldana (2014, p12) also claimed that qualitative data has “often been advocated as the best strategy for discovery, for exploring a new area and for developing hypotheses”. The qualitative data used within this study allowed exploration of Public Health involvement within licensing decisions, which was a reasonably new area for research studies.

Whilst there were several strengths to a qualitative research approach outlined in the literature, weaknesses with this type of study design were also highlighted. The less positive points of qualitative research focused on limitations of the researchers themselves, along with concerns over whether the findings were generalisable and an acknowledgement that it is difficult to replicate a study (Bryman, 2016). These criticisms primarily focus on the abilities of the researcher to complete the study along with competence in data analysis of the results. It is important to acknowledge the existence of limitations within all research studies, which places emphasis on the importance of the researcher in minimising these factors, to ensure the best possible research study is produced. Within this research, the weaknesses and limitations of the study are acknowledged. A short discussion of the limitations of this study are outlined at the end of this Chapter, with a fuller discussion of limitations discussed within the methods Chapter.

Within the available literature on research methodology, the term ‘worldview’ appeared. Four philosophical worldviews were outlined, and these were named as post positivist, constructivist, transformative and pragmatic (Creswell and Creswell, 2018, p5). Creswell and Creswell (2018) provided a definition of a worldview as “a general philosophical orientation about the world and the nature of research that a researcher brings to a study”.

The first worldview termed as post positivist, was suggested to be a scientific approach within which the researcher “identifies and assesses the causes that influence outcomes, such as those found in experiments” (Creswell and Creswell, 2018, p6). This study did not involve experimentation and therefore this worldview does not match with this research.

The second worldview of constructivist has also been called social constructivism and it is suggested that this worldview is often joined with interpretivism (Creswell and Creswell, 2018). It was proposed that within this worldview the researcher believes that the study

participants “seek to develop understanding of the world within which they live and work by developing subjective meanings of their experiences” (Creswell and Creswell, 2018, p8). Understanding for research participants was argued to develop through interactions with others combined with existing cultural norms and the researcher’s role was interpretation of the meanings held about the world (Creswell and Creswell, 2018). As this research study examined the meanings held by the participants around licensing decisions, there are elements of a constructivist worldview within this research.

A transformative worldview focused on research with marginalised groups and it was argued that in relation to these groups, “post positivist assumptions imposed structural laws and theories that did not fit” (Creswell and Creswell, 2018, p9). The worldview argued that social oppression of marginalised groups required any research study undertaken was required to link with politics and political change (Creswell and Creswell, 2018). The final worldview within the literature was labelled as pragmatic. This worldview was stated to occur due to “actions, situations and consequences rather than antecedent conditions” (Creswell and Creswell, 2018, p10). Within the available literature, the pragmatic worldview was proposed as focusing on problem solving, while the researcher’s role was to use every approach to gain an understanding of the issue (Creswell and Creswell, 2018). Within this study, the variable engagement of Public Health professionals within licensing decisions was identified as an issue.

Relating the varying worldviews to this research, this study most closely aligned with a constructivist worldview, as it aimed to examine the experiences of the individuals involved within licensing decisions and the meanings constructed by those individuals. There was a connection with a pragmatic worldview which related to gaining an understanding of the variable engagement levels by Public Health professionals within licensing and part of this research focused on the identification of possible enablers and inhibitors to partnership working, thus consideration was given to the identification of potential solutions to an issue.

Creswell (2013) proposed that the research process within qualitative research was emergent, which infers that the initial study plan would change and alter as the research progresses, including even after data collection starts. Creswell (2013, p47) argued that “the key idea behind qualitative research is to learn about the problem or issue from participants

and engage in the best practices to obtain that information”. This research was continually reviewed and refined as progress was completed based on emerging new data. This research therefore, also contained elements of an emergent design, specifically in relation to design flexibility to accommodate changes as indicated by emerging results.

Following on from methodological concepts that linked with this research and overarching research design considerations, the next section of this Chapter moves to outline the precise methods used within this study.

4.1 Study Design

During the preliminary development phase of the research, the intended study design underwent a few changes. The initial design proposed for this research was a mixed methods investigation, incorporating a baseline survey, followed by detailed interviews with informants. This design was subsequently altered following information that an official survey of all PH departments’ involvement in licensing in England was underway. The next intention was to conduct in-depth interviews and a case study within one London borough. A research proposal for a case study was sketched out in order to approach boroughs for access permission. Two London boroughs were approached for permission to complete a case study. In one borough, no response was received to the requests submitted by the researcher and by their supervisor and in the second borough after a period of six weeks, a refusal was received. The reason cited was that this area was already accommodating a research student and therefore they did not have the capacity to accommodate a further study. Due to these refusals to requests for access to a borough (after a prolonged period of negotiation), in a time limited study, the research design altered again.

The final research design agreed after the preparatory period used three complimentary sources of data:

- in-depth interviews across a number of London boroughs, with public health professionals, representatives of other responsible authorities, and policy/ regional level representatives;
- analysis of relevant documentation; and
- fieldnotes obtained through observation of Licensing Sub-committee meetings open to the public (in one London borough).

Ethical committee approval was sought before the research commenced. Within the sections below, an outline of the work completed and further details relating to changes in the study design are provided. The section covers:

- preliminary work, which included meeting with key informants, attending relevant conferences, meeting with the supervisory team at Middlesex university, and identifying relevant literature. Identification of London boroughs and participants to approach for participation and attendance at two licensing sub-committee meetings which were open to the public were also carried out.
- the main study included ongoing identification of literature sources, maintaining contact with key informants, producing interview schedules and completing data collection from three main sources (interviews, documentation and field notes).

4.1.1 Preliminary work

During the early stages of this PhD a set of initial meetings were held with four key informants. One of these informants worked at a national level in Public Health and Licensing, whilst another two individuals worked at the London regional level. The final key informant worked for an organisation that funds research. Two of the individuals worked specifically on licensing within London boroughs, one worked on Public Health and licensing but had other roles and responsibilities in addition to this remit and the final individual worked within alcohol research including licensing. This led to invitations to two events, the first being a Safe Sociable London Partnership (SSLP) event which was titled as 'London licensing network: useful tools for licensing in London' and the second was a PHE event called 'Alcohol licensing and Public Health: achieving our objectives together'. Within the first few months of commencing the study, the researcher also attended a conference at Middlesex University named 'Challenging perspectives on evidence and policy'. One informant advised contacting professionals who were involved in alcohol licensing research and policy work. The informant working in research suggested three key papers to read and these are outlined below in the literature review section. Another key informant also advised that PHE were completing a licensing survey and supplied the name of a contact person to speak to about this project.

The researcher signed up to receive newsletters from the Institute of Licensing, Drink and Drug News, The Faculty of Public Health, The Kings Fund, Drugscope Daily News, Institute of

Alcohol Studies, (IAS) Alert, Alcohol Focus Scotland, Alcohol Policy UK, The Greater London Authority and Public Health England's Alcohol E-shot. Subscriptions to these newsletters, allowed the researcher to become alerted to new developments in relation to the areas of Public Health and licensing. The researcher also attended two Licensing Sub-committee meetings open to the public in a local London borough with the aim of observing proceedings and to network with attendees. The observations proved to be not only informative, they inspired the completion of further observations of Licensing Sub-Committee meetings at a later stage within the research.

4.1.2 Literature review

Reviewing available literature is a traditional feature of a research study, involving the examination of existing knowledge as contained in a written form. The literature review completed within this study, however, did not follow a traditional path that includes the selection of key words for database searches, followed by a review of all articles and books produced by this search. As this study involved examining different 'bodies' of literature, the approach adopted was iterative, with literature searched dependent on information obtained from existing research articles and texts.

The first body of literature to be examined centred on general issues around alcohol policy. This was followed by a review of literature relating to licensing and more specifically, to Public Health involvement within alcohol policy. The aim of this review was to identify gaps in current knowledge and to extract relevant information regarding the role of Public Health in alcohol licensing. Searches were completed using the terms of 'licensing', 'Public Health', 'alcohol licensing' and 'licensing legislation'. Recommendations on relevant literature were also provided during initial meetings with key informants. Once this first body of literature had been accessed and reviewed, this led to other sources via articles, books and through the Internet. Middlesex University library catalogue, SUMMON and inter-library loans were utilised along with other online resources such as Google Scholar, Twitter and Mendeley.

The review of available literature proved that that while there was a large body of research pertaining to health policy, alcohol policy and alcohol issues generally, when concentrating specifically on the area of Public Health and licensing, there were reasonably few research

studies available (See Chapter 2). This opinion was corroborated by a key informant who stated, “In terms of publications, there aren’t many as yet - but a few are starting to emerge”

As Public Health were only added as a responsible authority in 2012, this relatively recent addition could be an explanation for the lack of research studies and documentation available. The materials that were available in addition, were mostly published at a national level and attempted to provide guidance for Public Health teams who wished to become more involved in licensing decisions, such as the Public Health England and Local Government Association’s (2014) document with the title of “Public Health and the Licensing Act 2003: A Guidance note on effective participation”. The documentation available at local authority level concerning alcohol licensing, centred on each borough’s Statement of Licensing Policy (SoLP).

The review of relevant literature continued throughout the completion of this thesis, as the information on this area altered and required updating at regular intervals. Other literature reviewed centred around elaborating the conceptual framework and theories chosen as relevant to developing the study design, data collection and analysis. These bodies of literature are discussed in Chapter 3. The health policy process literature was of primary importance due to its potential for providing an overarching conceptual framework within which to investigate the implementation of local alcohol licencing policy as well as theoretical frameworks for the interpretation of concepts.

Another body of literature for review, focused on partnerships and partnership working since collaboration with other professionals, in a range of agencies, was clearly a requirement for Public Health in their reasonably new role as a Responsible Authority and, as argued before, is regarded as a key mechanism for the implementation of policy especially concerning complex policy issues. Initial searches for materials using the terms ‘partnership working’ and ‘Public Health and partnership working’, led to a large amount of literature for review. To assist with processing the large body of literature around partnership working, specific authors who had written about health partnerships and/or addiction partnerships were chosen. Again, once initial sources of literature were accessed, this led on to other sources in research articles, books and through internet searches. The literature on professional identity

was reviewed later in the study following initial interviews as it became apparent that this was emerging as an important concept.

One point which emerged from the initial literature review and discussions with key informants, was the lack of clarity around Public Health involvement in alcohol licensing decisions. Across London, involvement in licensing processes was variable in each borough. To obtain a greater understanding of the current situation, a baseline survey was planned. However, it became apparent that PHE, were completing a survey that had similar aims as the proposal for this research. As Public Health departments were already being asked to complete a licensing survey, an assumption was made that any questionnaire sent for this research would only achieve a low response rate. PHE agreed to share the results of their 2015 survey but due to confidentiality, the results provided consisted only of aggregate data. This caused analysis difficulties as the data could not be cross tabulated to ascertain which boroughs had submitted which responses. Nevertheless, the data from the PHE survey was analysed and general themes emerged. For clarity, PHE completed a second annual licensing survey in 2016 and produced a report after the completion of the second survey. This report included information and conclusions from both the 2015 and 2016 surveys. Using this report, a short summary of the findings from the surveys was included within this thesis and this can be viewed within Chapter 2.

4.2 Ethical Committee Approval

An application was submitted to Middlesex University Ethics Committee and the research was approved in April 2015 (See Appendix 3). The Ethics Committee specify that each research participant should receive both an information sheet relating to the research (See Appendix 1) and a consent form (See Appendix 2), which must be signed by each participant.

4.3 Research Timeline

Prior to providing details relating to each stage of the study, the table below provides an overview of each stage of the project, along with the timelines.

Table 2: Research Stages

Project Stage	Actions completed
Preliminary Work Oct 2014 – August 2015	<ul style="list-style-type: none"> • Application for Ethics Committee Approval
	<ul style="list-style-type: none"> • Appraisal of Literature*
	<ul style="list-style-type: none"> • Identification and discussion with key informants
	<ul style="list-style-type: none"> • Observation of two licensing sub-committee meetings
	<ul style="list-style-type: none"> • Analysis of PHE licensing survey 2015
	<ul style="list-style-type: none"> • Attendance at relevant conferences/events*
Main Study: data collection Sept 2015 – Oct 2017	<ul style="list-style-type: none"> • Analysis of Documentation, including SoLPs
	<ul style="list-style-type: none"> • Interviews
	<ul style="list-style-type: none"> • Public Meeting Observations
	<ul style="list-style-type: none"> • Analysis of PHE Licensing Survey 2016 Report
Analysis and writing up Nov 2017 - July 2018	<ul style="list-style-type: none"> • Transcription of interview data • Analysis of interview data in parallel with field notes from meeting observations • Writing up

* Please note that appraisal of literature and attendance at conferences and events continued throughout the research and not only during the preliminary work stage.

4.4 Main Study

4.4.1 Sampling Frame

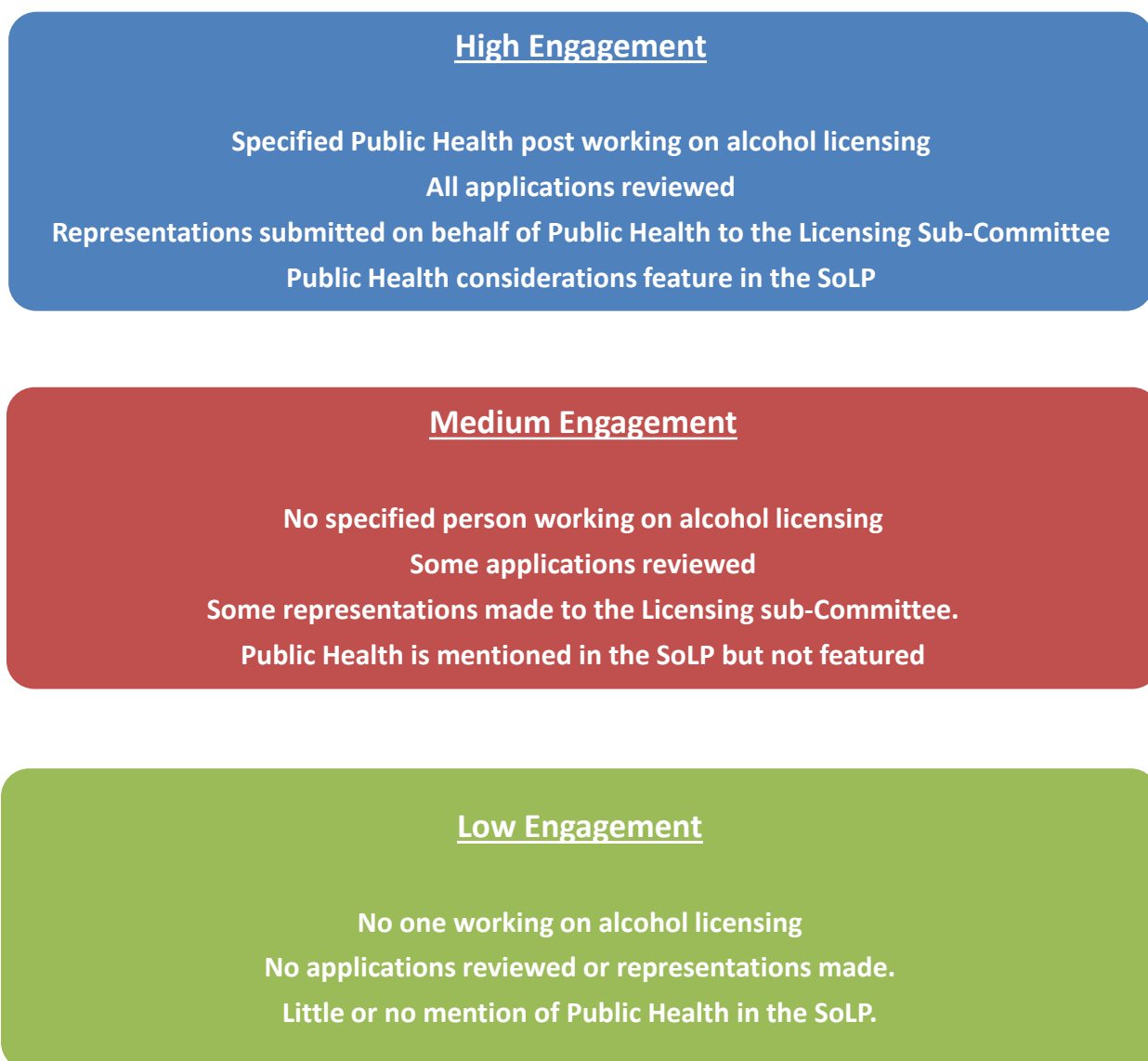
The potential sampling frame for this study was all thirty-three London boroughs. However, to identify which boroughs to approach, a regional organisation named Safe Sociable London Partnership (SSLP) was contacted. The sampling approach for the interviews were a convenience sample. However, the participants were purposefully selected to provide the

researcher with the potential to answer the research questions (Creswell and Creswell, 2018). As the main study progressed a snowballing approach was also used with each interview respondent being asked for recommendations for additional participants. This approach was particularly useful for gaining access to licensing professionals and other Responsible Authority groups, who were unknown to the researcher. It potentially introduced a source of bias, however, since, as the individuals were suggested by others, they may have been more likely to agree to participate in interviews.

SSLP were asked to assist with a subjective estimation, based on their experiences of working with each borough, of the exact level of involvement of each borough in licensing decisions. SSLP had previously worked with various London boroughs around licensing, they ran a licensing network and had developed a tool to assist Public Health departments to participate in licensing decisions. SSLP were therefore assessed as being in a good position to assign a level of involvement to each borough. As SSLP provided information on each of borough's levels of engagement within licensing, it is important to acknowledge their role within this study as a gate keeper. It was the subjective judgement provided by SSLP that led to the identification of boroughs for this research. This introduced bias into the sampling frame, however this method was deemed as the best option for sample selection as the initial aim, to categorise boroughs and select from respondents from a baseline survey was not achieved.

SSLP were initially asked to identify six boroughs, two where Public Health was highly involved in alcohol licensing decisions, two where the boroughs were engaged at a medium level and two boroughs, that were viewed as either having low or no involvement at all. The researcher developed a simple set of criteria that could assist in the estimation of engagement levels by Public Health within licensing decisions and this is outlined in Diagram 1.

Diagram 1: Criteria for assessing engagement level



As the research progressed additional boroughs were approached to request participation in the research due to some areas either declining to participate or not responding to requests for participation. SSLP were again approached to request information about additional boroughs to approach. By the end of the fieldwork, eleven London boroughs had been approached and agreed to participate, but in three of these areas, one Public Health team covered two London boroughs. This reduced the potential number of Public Health departments who were invited and agreed to participate to eight. For clarity, during the rest

of this thesis, in boroughs where one Public Health team covered two boroughs, they are referred to as one area.

Table 1 below provides a summary of each area that participated in this research. Please note that an analysis of each area’s Statement of Licensing Policy (SoLP) was undertaken during the research, therefore a partial examination of documentation was in fact undertaken in all the eight areas (eleven boroughs) who were approached to participate in the study. As it was envisaged that every borough would participate in the research, their SoLP was analysed.

Table 3: Details of London borough’s allocated engagement level and study participation

<i>Area</i>	<i>Engagement level</i>	<i>Interview/Meeting observations/Documentation analysis</i>
A	Medium	Interviews & meeting observations Analysis of all relevant documentation, including analysis of SoLP
B	Low	Interviews & analysis of SoLP
C	High	Interviews & analysis of SoLP
D ³⁴	Medium	Interviews & analysis of SoLP
E	Low	Interviews & analysis of SoLP
F ³⁵	Low	Analysis of SoLP
G	Medium	Analysis of SoLP
H ³⁶	High	Analysis of SoLP

Of the eight areas (eleven boroughs) listed above, three either did not respond to requests for participation in the study or declined involvement, which left five areas (six London boroughs). These five areas were labelled as Areas A, B, C, D (consisted of two London boroughs) and E. Area A, in addition to participating in interviews, consented to allow

³⁴ Consisted of two boroughs

³⁵ Ibid

³⁶ Ibid

observations of relevant meetings open to the public (primarily their Licensing Sub-Committee meetings) along with analysis of relevant documentation relating to licensing.

Despite attempts to ensure that two boroughs with high, medium and low engagement participated in the research, this was not achieved and therefore no further analysis of engagement level as a proxy measure of success involvement by Public Health teams in licensing decisions could be made.

4.5 Main Study procedures

The sections below outline the process and details of the interviews; the analysis of relevant documentation; the use of fieldnotes; and the data analysis.

4.5.1 Interviews

Using data obtained from preliminary work, interview schedules for the main study were developed. The interviews contained a series of questions, which could be broadly grouped into three key areas for investigation. These were:

- Policy Process - Questions asked about the individual's role within the licensing process, about decision making and definitions of acceptable evidence. Respondents were also asked about national/local policy development and they were questioned about their understanding of regional and national bodies, such as PHE and SSLP's involvement in licensing.
- Partnership working - Questions in this part of the interview asked about perceptions of the relationships with other licensing partners and for description of issues faced during partnership working. There were questions on the perceived levels of influence of each Responsible Authority group and if the different Responsible Authority groups in each licensing partnership had shared goals that were jointly agreed.
- Professional identity - Questions in this section asked about the professional education and training background of respondents, on the addition of Public Health as a responsible authority and on the relocation of Public Health from the NHS to local councils.

All questions within the interviews were open ended and included probes and prompts, to obtain further information as necessary. The interviews were flexible, with questioning

adapted based on the interviewee. Potential interviewees were initially contacted via email with a request for an interview (with a study information sheet and consent form attached). If no response was received to the first email, a second email was sent. If a response was again not forthcoming then a telephone call was made to request an interview, with two subsequent follow up calls.

All participants were given the option of a telephone interview or face to face, which resulted in some interviews being completed in person (6 interviews), others by Skype (1 interview) and telephone (14 interviews). The venues for the face to face interviews were primarily work based locations but on one occasion an interview was completed in a café at the request of the interviewee. One interviewee had moved abroad which resulted in the completion of the interview via Skype. This interview was conducted without any technical hitches but due to time differences, negotiation was involved over a suitable time to complete the interview. The interviews conducted over the telephone on two occasions suffered issues relating to loss of phone signal, but this did not appear to interrupt the flow of the interview. The interviews lasted between twenty minutes and one hour depending on the responses received.

Concerning the selection of participants for interviews, the initial proposal involved targeting professionals working within Public Health and the licensing authority. Supplementary interviews were also planned with professionals from other Responsible Authority groups, local councillors who sat on the Licensing Sub-Committee meetings plus regional and national organisations who were involved with licensing.

As the interviews were investigating areas that included policy implementation, strategy and partnership working in addition to frontline work practices, it was identified that there were two levels of professionals who required to be targeted for interviews, within the overriding groups of Public Health and the licensing authority. Interviews were therefore completed with a strategic person (who dictated strategy and policy implementation) and a front-line member of staff (the professional who reviewed licensing applications, wrote representations and presented these to the Licensing Sub-Committee), in each borough and the interview schedules were amended to reflect these different roles. This decision aimed to ensure that maximum understanding of the phenomena under investigation was gained.

The front-line professional was potentially not involved in licensing decisions at a strategic level and the senior strategic person may not have been the professional who represented Public Health at Licensing Sub-Committee meetings. As there were four areas (one area consisted of two boroughs) participating in the main study this process was replicated for each borough. In consultation with the supervisory team, having two levels of interviews was not deemed appropriate or achievable for the other Responsible Authority groups as it was arguably only frontline staff who participated in licensing decisions at local levels. A series of differing interview schedules was developed for interviews with each professional group (See Appendix 4 for schedules).

In addition to the interviews with Public Health and licensing respondents, interviews were obtained with a police licensing officer, two local councillors who participated in Licensing Sub-Committee meetings, one regional organisation and two national organisations who all had a remit around licensing. To obtain a wide overview of Public Health involvement within licensing, interviews with a range of professionals were required and the inclusion of interviewees from regional and national organisations allowed some examination of issues regarding regional and national policy on licensing with implementation and practice at local levels.

Table 2 below, provides an overview of the interviews completed in each area. To assist with the analysis of the interview data, each respondent was allocated a reference, using a simple system of alphabetical letters and numbers. Each Public Health respondent received PH, followed by a number, starting at 1 (for e.g., PH1, PH2). Each licensing respondent was labelled as L, followed by a number (for e.g. L1), P was allocated for Police, C for councillor, R for regional and N for national, with the same numbering system applied. For example, N1 for the first national organisation and N2 for the second. This same system was applied to each respondent's interview.

Table 4: Overview of Interviews

<i>Area</i>	<i>Strategic Licensing</i>	<i>Strategic PH</i>	<i>Frontline licensing</i>	<i>Frontline PH</i>	<i>Others</i>	<i>Job Title</i>
A	L1	PH1	--	PH2	C1, P1, C2	1 Licensing manager; 1 PH project manager; 1 PH Strategist, 2 Councillors, 1 Police Licensing Officer
B	--	PH3	L2	PH4, PH5	--	1 Assistant DPH 1 PH Strategist 1 Regulatory Services Officer (who acted on behalf of PH) 1 Licensing officer
C	L3	PH6, PH7	--	PH8, PH9	--	1 DPH 1 Consultant in PH 1 PH registrar 1 PH strategist 1 Licensing Manager
D³⁷	--	PH10	--	PH11	--	1 Consultant in Public Health 1 PH Strategist
E	--	PH12	--	--	--	1 Assistant Director of PH
R1						1 Regional organisation representative

³⁷ Two London boroughs

N1, N2		2 representatives from National Organisations ³⁸
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In area A, interviews were held with two Public Health respondents, one strategic (PH1) and frontline (PH2), licensing strategic (L1), two Licensing Sub-Committee councillors (C1 and C2) and a police licensing officer (P1). Interviews were requested with Trading Standards and Environmental Health, but these were not achieved. In area A, the researcher was informed that the frontline licensing officer was also classed as the strategic lead due to their experience level. The head of regulatory services within that area, who held the title of licensing strategic lead, declined to be interviewed. For the purposes of this thesis therefore in area A, the licensing officer was interviewed as a strategic person.

In area B interviews were completed with Public Health strategic and frontline professionals and a licensing frontline officer (L2, PH3, PH4). In this area, the person interviewed and tasked with responding as the Public Health Responsible Authority, did not have an educational background within Public Health (PH5).

In area C, interviews were obtained from two Public Health strategic professionals, (PH6 and PH7) and two frontline Public Health staff were interviewed (PH8 and PH9). One strategic licensing professional was interviewed (L3). Despite several attempts to engage a front-line licensing officer, no one agreed to an interview.

In area D, only Public Health professionals participated in interviews, strategic (PH10) and frontline (PH11). Licensing professionals were contacted but no response was ever received to requests for participation in this study.

In area E, despite a Public Health respondent participating in the pilot interviews (PH12) and agreeing to further contact, no agreement was obtained subsequently for participation in an in-depth interview.

One regional organisation, which was involved in licensing amongst other areas of work, provided a representative for interview (R1) as did two national organisations. One national

³⁸ To protect the anonymity of the participants from national organisations, further details are not provided.

organisation was more involved directly in licensing work (N1) than the second organisation (N2).

4.5.2 Documentation

Three bodies of documents were selected for inclusion in this thesis. The first of these were PHE licensing surveys, which had been completed during 2015 and 2016. A short report was produced based on these surveys by PHEs London Regional Office. As these surveys were not conducted by the researcher, the report on the results of these surveys is included within the context sections of this thesis within Chapter 2. The second body of documents were the SoLP for each borough that was approached for inclusion within the study. For full information on the analysis of SoLPs, please refer to the Findings Chapter.

In addition to interviews and analysis of their SoLP, in area A all documentation containing the words 'alcohol', 'alcohol licensing' and 'Public Health' was reviewed. Creswell and Creswell (2018) proposed that documentary analysis brought several benefits to research. These benefits relate to providing easy access to written material that did not require transcription. The data contained within documents in addition, represented material that participants had spent time on and it allowed the researcher to gain an understanding of the language and words participants use (Creswell and Creswell, 2018). Within this research language was a feature, especially in relation to the acronyms and terminology used by professionals within written documentation. Analysing documentation was noted to have disadvantages however, such as the potential that relevant documentation may not be available within the public domain and the fact that the researcher has to rely on the accuracy of each document (Creswell and Creswell, 2018). For this study, the examination of grey literature was completed by a desktop search, primarily on each borough's, local authority website and by using the search engine google. Documentation was examined from the specific start date of 1st July 2016 and then all documentation for a period of six months into the future and one year into the past was scanned. This approach identified five key documents, and these are listed below:

- The Council Plan (2015-2018)
- The Joint Strategic Needs Assessment (JSNA)
- The Health and Well-Being Strategy

- The Statement of Licensing Policy
- Responsible Retailers Scheme

Based on information from available literature and the emerging data, the researcher developed a checklist for the analysis of each document (See Appendix 5). The main areas of examination focused on text that documented the role of Public Health within licensing decisions, the goals set and the outcome of partnership working. The main documentation source containing the largest amount of information on the involvement of Public Health within licensing decisions was the SoLP, with other documentation only briefly mentioning general alcohol policy work without specific mention of licensing. The SoLPs are discussed in a separate findings section as they present the main information in relation to how each licensing department operates in relation to licensing policy and decision making within each borough. The other documentation that was reviewed did not contain information that specifically focused on alcohol licensing.

4.5.3 Meeting Observations

As previously mentioned, during the preliminary stages of this study, the researcher attended and observed two Licensing Sub-Committee meetings in a local borough (Area B). These observations provided a different perspective on licensing decisions than data that was contained within the literature. In this borough, there were two Licensing Sub-Committees, which for the purposes of this study, are referred to as X and Y. Each committee had its own chairperson and normally three councillors sat at each meeting. Additional meetings identified were the Health and Well Being Board (H&WBB), the Community Safety Partnership (CSP) meetings and the Responsible Retailer scheme meetings. The researcher monitored agendas for the H&WBB meeting and the CSP meetings, but during the seven-month period over which observations were completed, alcohol licensing was never an agenda item for discussion at these meetings. The researcher also requested information on Responsible Retailer meetings, but as far as they were aware, no meetings were held of this group during the observation period.

The observations completed therefore were on Licensing Sub-Committee meetings and special Licensing Sub-Committee meetings. Routine Licensing Sub-Committee meetings usually occurred fortnightly but there were occasions when the meeting was cancelled.

Special Licensing Sub-Committee meetings were normally called at short notice in response to a review of a premises license. The schedules of meetings were all displayed on the local authority's online meetings calendar, so the researcher relied on this being updated regularly and on identifying changes, such as the addition of special meetings into the calendar.

Licensing Sub-Committee meetings were observed between July 2016 until the end of January 2017. Initially, it was planned to observe meetings over a six-month period, but this increased to seven months as there were two meetings the researcher was unable to attend, and a few meetings were cancelled. Fourteen meetings were observed (6 Licensing Sub-Committee X meetings, 4 Licensing Sub-Committee Y meetings and 4 Special Meetings). Similar to the analysis of documentation, using information gained from the available literature and the emerging data, a field notes form was developed for these meetings (See Appendix 6). This was used as an aide memoire for the researcher to record fieldnotes rather than as a standard questionnaire. Although each meeting discussed different cases, there was a standard agenda, which was followed during each meeting. For example, the chair would convene the meeting and introduce everyone present. The first case would be outlined by the Licensing Authority and any representations would be outlined. The responsible authority who submitted the representation or called for a license review would speak and then the applicants and/or their representative would speak. Once everyone had received an opportunity to present, the councillors would adjourn the meeting to make their decision. The final decision could be delivered at the meeting or alternatively the applicant and their representative would be sent away, being told that they would be notified within five days of the outcome of the committee. Only once was that same applicant observed at two meetings due to one meeting being convened for a licence review, followed by a second special meeting a few weeks later to discuss requests for Temporary Event Notice (TEN) applications.

As previously mentioned, there were two Licensing Sub-Committees with two separate councillor chairs. This appeared to affect the overall running of the committee. At special committee meetings, at times a different councillor chair was present, which also impacted on the overall management of the meeting. For example, one special meeting with two agenda items lasted for over six hours whilst other special meetings were completed within one hour. The issue of the impact of the Licensing Sub-Committee chairperson was also an

issue that was mentioned within the interviews. The data obtained from fieldnotes at each meeting were grouped and common themes were identified by the researcher. The results produced interesting data around the legal ideology surrounding Licensing Sub-Committee meetings, the role of members of the public within the procedures and decision-making processes.

4.6 Analysis

The interviews, documentation and field notes from observations were a rich data source for analysis within this study. The SoLPs were grouped together and reviewed as a separate body of data. Bowen (2009, p: 32) argues that document analysis involves “skimming (superficial examination), reading (thorough examination) and interpretation”. In relation to the SoLP for each borough, each one was skim read, then read in depth and based on this research a checklist for the analysis of each SoLP was developed (See Appendix 6). Using the checklist each SoLP was reviewed and themes that emerged were written into a report on SoLPs.

Bowen (2009) suggested five functions of documentary analysis and these were:

- To provide context on the environment within which the research participants operate.
- To suggest questions that need to be asked and situations that need to be observed.
- To provide supplementary research data.
- To provide a means of tracking change and development and to be analysed.
- As a way to verify findings or corroborate evidence from other sources.

Within this research, the analysis of documentation was used for providing context, to provide supplementary research data and in a small way, as a method for verification of evidence from other sources.

In analysing the interviews, steps suggested by Creswell and Creswell (2018) were followed. They suggested that the analysis of qualitative data follows a series of steps. The first step involves organising the data into a state that means it can be analysed (Creswell and Creswell, 2018). Within this research, all interviews were transcribed. The next suggested step is to spend time examining the data prior to coding, to gain an understanding of what is contained within it (Creswell and Creswell, 2018). In this study the proposal for analysis of the

emerging data was to use NVivo10. Training on this software was subsequently attended and after transcription, each interview was entered onto NVivo10. During the completion of fieldwork however, NVivo10 was updated and NVivo11 became the software version available to download from Middlesex University's website. There were a few changes within the updated version, that had to be navigated by the researcher as the training given was on an earlier software version. There was a specific requirement that all interview transcriptions had to be completed in Microsoft Word, to be entered into NVivo11 for thematic analysis.

Once data was incorporated into NVivo11, thematic analysis was used to identify common themes. Braun and Clarke (2006) suggest that thematic analysis can be used with conceptual frameworks and they argue that "through its theoretical freedom, thematic analysis provides a flexible and useful research tool, which can potentially provide a rich and detailed, yet complex account of data" Braun and Clarke (2006, p4). In this study, parent nodes were created on NVivo11 based on common themes identified within the data. Braun and Clarke (2006) suggest that within thematic analysis there are two approaches, which they termed as inductive and theoretical. Within this study the thematic analysis approach used was data driven and therefore inductive (Braun and Clarke, 2006). Braun and Clarke (2006, p83) argued that inductive analysis is "a process of coding data without trying to fit it into a pre-existing coding frame, or the researcher's analytical preconceptions". In this research, although the theoretical concepts and frameworks influenced the nodes created on NVivo11, the themes were obtained from the data and not purely theoretically driven. Each parent node was given a title. These were knowledge and knowledge transfer, evidence, professional identity and partnership working. Other themes were identified from the data and added to the four parent nodes as child nodes, due to their relationship with the main parent nodes. Braun and Clarke (2006, p86) refer to this process as "searching across a data set – be that a number of interview or focus groups, or a range of texts – to find repeated patterns of meaning". After this stage of analysis however, NVivo11 was no longer used (see reflective account later in this Chapter).

Miles, Huberman and Saldana (2014) proposed a system for qualitative data analysis that consisted of three parts, named as data condensation, data display and drawing/verifying conclusions. The first stage of data condensation involved making decisions over which data to include and which to discard, which is like Creswell and Creswell's (2018) step of

organising and preparing the data. Miles, Huberman and Saldana (2014) suggested that data condensation was a continuous process which only finishes with the publication of the research. During the data analysis for this thesis, decisions over data inclusion were complex and this process continued with each new draft of the thesis. The second stage suggested was data display, defined as “an organized, compressed assembly of information that allows conclusion drawing and action” (Miles, Huberman and Saldana, 2014, pp12-13). As previously mentioned within this Chapter, although initially NVivo11 was planned as the method for displaying the data obtained, this was not the only source of data display. All data was stored on NVivo11 with nodes created but some data from the interviews was displayed in a written format on paper. In addition, for data obtained from documents and meeting observations, paper again was the main source of data display.

The final stage of conclusion drawing, and verifying was also an ongoing process within this research. Miles, Huberman and Saldana (2014, p13) proposed that “from the start of data collection, the qualitative analyst interprets what things mean by noting patterns, explanations, causal flows and propositions. The competent researcher holds these conclusions lightly, maintaining openness and scepticism, but the conclusions are still there”. These authors argue that the final conclusions may not appear until after data collection was completed, but these have often been prefigured from the beginning (Miles, Huberman and Saldana, 2014). Within this research there was an ongoing cycle of analysis and at each stage, the emergent data was examined, and alterations made to the study findings. Within Creswell and Creswell’s (2018) work, two final steps were suggested, which were named as ‘generate a description and themes’, followed finally by represent the description and themes. These final two steps were similar to the final stage of conclusion drawing and verifying suggested by Miles, Huberman and Saldana (2014). For a full outline of results from this study, see the later Chapters on Findings, which is followed by Discussion and Conclusion Chapters.

Once main themes were available from the interview data, the information from observations was scrutinised and arranged under similar themes. The interviews and fieldnotes from observations were viewed as complementary methods and were analysed in parallel (convergently) to allow for a modest degree of triangulation and for more detailed conclusions than could be reached using only participants’ self-reported accounts. In practical

terms, this meant that the data obtained from the interviews could be reviewed with the data from the observation to present a more thorough picture of the actual procedures involved in licensing decisions, as well as of Public Health professionals attempts to engage.

A convergent approach to collating the findings was chosen because it met the exploratory and hypothesis generating nature of the research. The purpose was to use data from different sources to gain insights into the factors influencing the role of Public Health in licensing decisions and to generate common themes emerging from the research. The subjective accounts provided by interview participants could, to a modest extent, be viewed against the more objective observation of events and actions at the licensing committees. The data obtained from interviews and field notes was analysed at a similar time and during this timescale, the emerging data was reviewed, and changes were made to the data collection based on this (Fetters et al, 2013). For example, in an interview it was mentioned that the licensing officers are not present when the committee decide about an application so at the field notes stage of observations the researcher made sure to observe the procedures relating to decisions.

As can be viewed in the chapter on Findings, the emerging themes from interviews and field notes of meeting observations were weaved together to present an overview of the involvement of Public Health within licensing. Fetters et al (2013) refer to this process as “integration through narrative” (2013, p: 2142) where a weaving approach involves writing [both qualitative and quantitative] findings together on a theme by theme or concept by concept basis. In this thesis, two sets of qualitative data were weaved together to provide a narrative account of the experiences of professionals engaging within licensing partnerships.

This approach to the findings raised the question over whether these two data sources would produce similar findings. Fetters et al (2013) argued that during the application of this process there are three outcomes. The first was named as confirmation, which occurs when the data from one source confirms the findings from the other. The second outcome was named as expansion, which was defined as “expansion occurs when the findings from the two sources of data diverge and expand insights of the phenomenon of interest by addressing different aspects of a single phenomenon or by describing complementary aspects of a central phenomenon of interest” (Fetters et al, 2013, p:2143-2144). The third

outcome relates to inconsistencies in the findings between the different data sources (Fetters et al, 2013). In relation to this research, the findings provided a small element of confirmation, with a higher level of expansion. To have completed a separate analysis on interviews and field notes from observations, would not have afforded this level of expansion and confirmation.

4.7 Ethical approval and ethical considerations

Ethical approval for this research was applied for during Spring of 2015 from Middlesex University Health and Education Ethics Sub Committee. Approval was subsequently granted (See Appendix 6). Data sources, such as national statistics and the documentation analysed for this study, were publicly available data. One exception to this was Public Health England's (PHE's) licensing survey reports. Permission to access these was obtained from PHE, but as the reports were not published in the public domain, a request was made of the researcher that they did not widely disseminate this documentation.

Whilst the design of this research presented no major ethical considerations, as there was no potential for any participants to be harmed during the research for example, issues over confidentiality proved important. All participants were informed that their participation in the research was voluntary and that they could withdraw from the study at any time and without a requirement to provide a reason for withdrawing. During the interview stage, a few participants expressed concern over the maintenance of confidentiality as they wished their identities to remain anonymous. This has been respected and participant characteristics have been described only as complies with preserving anonymity.

To gain increased understanding of the involvement of Public Health in licensing decisions, the researcher wanted to observe relevant meetings within one borough and produce field notes. Permission to complete qualitative research was sought and granted by the Director of Public Health within Area A. Permission to observe these meetings was also confirmed by a council officer. These were all meetings open to the public to attend. As the Licensing Sub-Committee meetings were public meetings, they could be observed and at no point did anyone express concern in relation to confidentiality in this forum. No minutes from these

meetings were used within this thesis, the data used purely relates to the researcher's field notes taken during the meetings.

At the start of the meeting the chairperson informed those present that there was a researcher present. Despite being told about my presence, the individuals being observed appeared oblivious to the presence of a researcher. The advantages of observations, proposed within the available literature, concerned having a shared experience with the research participants, being able to record information as it occurred and make notes of any unusual occurrences (Creswell and Creswell, 2018).

All interviews with individual participants were audio recorded using an electronic recording device and transferred to the researcher's password protected personal computer. These files were transcribed and placed on Nvivo11 (also password protected). Every participant was offered the opportunity to view a copy of their transcript, but no one accepted this. To ensure anonymity for participants all personalised data was removed from interview transcripts. Each respondent and their geographical location in London have been anonymised by a system of letters and numbers, for example Public Health respondent 1 from area A. Only the researcher and their supervisors are aware of these codes. After completion of this research all audio files of interviews and documentation such as SoLPs, will be destroyed as per data protection legislation in the UK.

4.9 Issues and Limitations

Whilst this study provided an overview of Public Health involvement in licensing decisions and added new knowledge to understanding in this area, it remains important to acknowledge the potential issues and limitations of this research.

The first issue that became evident while completing this study, related to the necessity to alter the study design. The initial planned baseline survey was omitted, which would have provided a broad base of information. Also, the proposal to complete a case study in one borough, which would have provided a more rounded, in-depth understanding of some issues, was not achievable. The study design also altered due to limitations on the number and spread of interviews completed.

Within this research, the sample invited to participate was based on advice from a regional organisation. A random sample could have been approached, but it was decided that the main aim was to gain understanding of Public Health involvement in licensing and that this could be achieved by focusing on a small number of contrasting local contexts rather than aiming for a larger representative sample of all London boroughs. Moreover, practical issues of time and resources had to be considered. The credibility and quality of the conclusions were based on the qualitative data obtained providing rich details of the lived experiences of the respondents who were participating in this project.

Turning to the limitations within this study, the first related to data analysis and the dependence upon the researcher's abilities. A large quantity of data was gathered from the combination of interviews, observations and analysis of related documentation. Transcribing data and grouping it for inclusion in NVivo11 was time consuming. This limitation did not appear, however, to compromise the research.

There was also a potential limitation arising from the researcher's subjectivity and bias. Using the data analysis as an example, the researcher made decisions over which themes to include within the analysis and this may have been affected by internal biases held by the researcher. As previously mentioned the researcher worked within Public Health prior to commencing this research; this could potentially mean that the researcher took a more favourable view of the opinions of the Public Health participants in comparison to the other responsible authorities through unconscious bias

The position of the researcher as an insider (known to the interviewee or meeting attendees) or an outsider (unknown to interviewee and meeting attendees) (Milligan, 2016) may also be a potential source of bias. At different times the researcher was positioned as either an outsider or an insider. This will be discussed in further detail in the reflective account later in this Chapter.

As an insider, the researcher could have influenced the interviewee by presenting questions in certain ways and by applying 'insider' knowledge within the context of the interview or meeting observation. On a more positive note however, being positioned as an insider did appear to achieve a greater level of access to research opportunities within this study. This

research was completed on a small number of participants, with the majority being Public Health professionals. This greater number of interviewees with a background in Public Health could have created a bias towards the views of Public Health professionals and whilst many attempts were made to engage interviewees from differing Responsible Authority groups, these requests did not result in additional interviews being granted.

Another limitation concerned the accuracy of the data obtained, which was dependent on the openness and honesty of the interview participants. This limitation was partially reduced by checking the accuracy of data received during interviews with additional sources, such as a different interviewee or within a meeting observation. It became evident during completion of the study however, that, at least occasionally, information provided within an interview did not correspond with practice. For example, in one borough during an interview with Public Health, the researcher was told that meetings between all Responsible Authority groups were occurring, but during the seven-month observation period, no meetings of this type took place.

Finally, the impact of the location of this study requires acknowledgement as a potential limitation. This study was completed in the region of London. London is different to other areas of England in relation to being primarily an urban area and a tourist destination, which influences both alcohol consumption and licensing decisions. Regardless of this geographical issue, the findings and conclusions emerging from the thesis will be relevant and of interest to Public Health practice outside of this location.

4.10 Reflective account of the Research

Within the following sections of this thesis, I will provide a reflective account concerning how my views developed over the course of my research journey and how my positioning as an insider/outsider researcher altered at various points during the study. My reflective account follows my study from preliminary work through to analysis and writing up. Through this reflective account I aim to provide a narrative account of how this research has influenced my professionalism and how my own professional status influenced the study design and findings. To write a reflective account, it could be argued that it would be useful to define the term reflection. Within the literature there are several definitions of reflection (for example, Dewey, 1933; Schön, 1987; Reid, 1993). Although there is variation in these definitions, such

as whether the definition refers to reflection or reflection in action (Schön, 1987), the common point is that reflection involves looking back. Reid (1993; p:3) in relation to nursing practice, defines reflection as “a process of reviewing an experience of practice in order to describe, analyse and evaluate and so inform learning”. Clarke and Graham (1996, p:26) discuss the process of reflection and state that “by engaging in reflection people are usually engaging in a period of thinking in order to examine often complex experiences or situations. The period of thinking (reflection) allows the individual to make sense of an experience, perhaps to liken the experience to other similar experiences and to place it in context”. A reflective account within the context of this research, involved reflecting upon the decisions made within the research and the impact that my prior experiences, may have had on those decisions. My research was not focusing on my professional practice, instead it explored the practice of researching and my role as a researcher.

Prior to commencing this PhD, I worked within local government within a Public Health department in London. I had held this position for several years. When Public Health were added to the list of Responsible Authorities, I was given responsibility for licensing. This was a difficult role as initially, although there had been guidance issued at a national level, implementation of this policy at the local level was difficult within the borough where I worked. It was time consuming to review licensing applications. Due to the number of applications received monthly and the fact that licensing was one role amongst others, we (public health professionals) tried to engage as best we could. Attempts to find out information relating to the practical processes regarding ‘how’ Public Health could input into licensing, had proved difficult. I was interested in the topic though and when I saw an opportunity for a funded PhD about the engagement of key stakeholders within licensing decisions, I viewed this as a way of investigating potential reasons behind the difficulties I had experienced in engagement.

As a Public Health professional, I was committed to the idea that Public Health had a valid role to play in licensing decisions and that data relating to health should be attributed the same evidential value as other sources of information. I was also interested in licensing and the history of the developments and changes in licensing within a legal system.

Preliminary work

During the early stages of the research, through reflection, I can identify two main shifts that occurred and these related to a change in my own views and attitudes concerning the topic and a second shift related to the design of the research.

When I started the PhD and met informally with a couple of key informants, there were suggestions made over which key stakeholders that these professionals would like included in the study. For example, I was told that one organisation had noted that Children's Services and Planning Departments, did not engage in licensing decisions and that this organisation would find it useful if this was investigated further. I wished to focus on the key stakeholder group of Public Health. Attempts were made to request interviews with a range of Responsible Authorities during the main study, but this proved unsuccessful as responses were not received to these requests.

As I began reviewing available literature, attending events and meeting with key stakeholders, I felt that the involvement of Public Health in licensing was necessary. During the early stages, I naively imagined that I was going to complete the PhD, produce conclusions and a set of findings to inform good practice for Public Health professionals that would assist in the more effective involvement in licensing. As time progressed however and I increased my knowledge around the topic, I found I was beginning to question the essential rationale for the involvement of Public Health in licensing. I became more aware of the gap between policy and practice through reading literature and discussing the subject with key informants. I also began to think about what would happen if Public Health did not input into licensing. For example, would population health reduce if Public Health departments did not submit representations to licensing applications?

The second shift related to the design of the research. This occurred not due to any alteration in my opinions of the topic, rather this was necessitated by circumstances. I had planned to follow a traditional approach to the investigation of the topic, in that I planned a literature review, a mixed-methods design of a quantitative survey followed by qualitative interviews and analysis of the qualitative data through Nvivo11. During the preliminary work, it emerged that a traditional literature review on Public Health involvement in licensing decisions was

not achievable, due to the recent addition of Public Health as a Responsible Authority, this area was a topic which was new and only a few research papers existed. The study design changed after it became apparent that a national organisation was completing their own survey. By the time I received this information, I had already drafted my own version of a survey; there was therefore feelings of frustration relating to time spent producing a survey that would not be used. The change of study design later become a positive point however as I used the questions designed for the survey within my interview schedules for the main study. It was also reassuring to observe that when I viewed the PHE questionnaire, the questions asked by PHE focused on areas that were similar to my questions, although my study asked additional questions that the PHE survey did not.

I learned quickly in the preliminary stages that to achieve completion of this study, would require adaptability and flexibility in the research design. I was also learning skills relating to planning and time management. For example, the application to the ethics committee, involved planning for how time and tasks would be managed whilst awaiting the next ethics committee meeting. In addition, I learned to deal with setbacks and continue working. For example, when I could not complete a baseline survey and had to alter the study design or when a borough for a case study could not be found.

During the preliminary stages, I also began to gain an understanding of the complexity of licensing decisions and about the variability between different London boroughs concerning how each Public Health attempted to engage with the other Responsible Authorities in licensing partnerships. For example, in the first area which agreed to participation, licensing professionals reported that they could not get Public Health to be involved in licensing. This was a very different situation to the London borough where I had worked prior to starting this research. In this borough, Public Health professionals were attempting to engage in licensing, but it was proving a difficult task.

Main Study

The main study consisted of interviews, field notes from the observation of licensing sub-committee meetings and analysis of relevant documentation. It was during this stage that the issue of being an insider or an outsider or operating in the space between (Buckle and Dwyer,

2009), featured most strongly. Ryan (2015, p:1) proposes that the concept of positioning raises the question of “what or where are we inside or outside of?” and it is on this point that this reflective account primarily focuses from the perspective of the researcher.

Milligan (2016, p: 239-240) argues that “in conducting research we are neither entirely one identity nor another, neither fully inside nor outside. Rather, it is argued that researchers take on different positionings dependent on the situation that we may be in, the people we are interacting with and familiarity of the linguistic and socio-cultural norms”. During this study there were elements of being an insider, where I had privileged knowledge about Public Health involvement in alcohol licensing and where accessing participants was easier due to this knowledge (Dwyer and Buckle, 2009). Within my study, I had prior experience within licensing decisions, however this experience was not overtly used within the interviews. For example, the participants were not questioned in a leading way, such as asking if the processes in their boroughs were the same as in the borough within which I worked. Within this study, whilst an acknowledgement was made of the potential bias that my experiences of licensing could introduce, on reflection, it would have been impossible to completely exclude my previous knowledge and experiences of licensing from this research.

Within available literature, it has been argued that being positioned as an insider allows the researcher to be better placed to identify research questions and that prior knowledge of the subject area means the researcher has a reduced risk of being misled by participants (Hodkinson, 2005). On reflection, during the initial stages of this research, the positioning as an insider did appear to allow me to progress through the study at an increased rate. In addition, as the study progressed and recruitment of professionals for interviews was proving difficult, using privileged, insider information appeared to be the only way to facilitate access to potential participants.

It has been argued that positioning as an insider also causes issues in relation to the researcher being unable to separate their experience from the participants (Kanuha, 2000), being unable to address questions about potential bias in their research or face issues of confidentiality around sensitive issues (Serrant-Green, 2002). On reflection, the topic being investigated for this research was not an emotive subject for myself or the participants. I therefore do not think that I was unable to separate my experiences from participants. I think

that when interviewing participants who were known to me, they provided me with additional information that they may not have done if I was a stranger. In one interview, although the participant was not known to me, I was familiar with the borough. Due to the insider information relating to the borough, after the interview finished and the recording was terminated, the interviewee proceeded to give me additional information about licensing decisions that was opposite to the recorded interview information. I believe this would not have happened had I not been an insider.

This scenario did present an ethical issue that I discussed with my supervisors concerning, whether I could use the additional data that was provided after the recorder had been turned off. The decision was taken that I could use the information as firstly, I had not been asked not to, secondly the interview was technically still occurring as we were still in the interview room and finally, the anonymity of the participant was maintained. However, it was also agreed that no direct quotation would be used from the unrecorded part of the interview and that it would be used to augment my understanding and further investigation. If the participant had said not to use that data, I would of course have agreed as I would not have had permission to use it. The issue of potential bias introduced by insider positioning is a point that requires addressing. The modest degree of triangulation introduced by the parallel analysis of the data (interviews and fieldnotes) was the main method used to overcome this.

At other points in the study my positioning moved towards being an outsider. For example, when I produced field notes from the observations of Licensing Sub-Committee meetings, my positioning was towards an outsider, as this particular context was a new experience for me, within an unfamiliar environment. I was however, not completely an outsider as I was familiar with the borough. Dwyer and Buckle (2009) argued that it is only in a minority of cases that someone can be characterised as a complete insider or outsider. Other researchers such as Mercer (2007), point out that the identity of the researcher is often relative and can change based on the research setting, the personalities involved and the topic. On reflection, my positioning within this study changed as the study evolved. In some contexts, such as interviewing individuals who were known to me, my positioning moved towards being an insider but in other contexts, such as observing licensing sub-committee meetings in a borough unknown to me, I moved towards being an outsider. This was a learning point for

me in relation to the fact that you don't have to be either an insider or an outsider in relation to positioning as a researcher and that your position can alter, dependant on the context.

Analysis and Writing Up

The proposal for the analysis of the data was to use Nvivo11. This appears to have become the standard approach for analysis of data, but some authors have mentioned limitations with software for analysis (Maher et al, 2018). I attended training at Middlesex University on the Nvivo software system and whilst NVivo11 was invaluable for data storage and identification of both parent and child nodes within the data, the actual analysis to identify common themes was completed by myself using pen and paper. Maher et al (2018, p:11) suggested that using pen and paper allowed "the researcher great freedom in terms of constant comparison, trialling arrangements, viewing perspectives, reflection and ultimately developing interpretative insights".

At the point where the data required analysis to extract key themes, I found that it was difficult to apply NVivo11 when themes crossed. For example, around the theme of knowledge sources there were themes that crossed with professional identity. Due to this I felt unable to use NVivo11 to clearly view all of the data to identify the key themes and to make comparisons. Maher et al (2018, p:12) suggested that the Nvivo software package was very useful for data management and for retrieving information but it did not "scaffold the analysis process". These authors suggested that the limitations of software packages for data analysis related to the small computer screen size which meant that the researcher could not gain an overview of all of the data, that memory was used for decision making due to data retrieval being completed on the software where there was less creative encounters and these factors led to fragmentation (Maher et al, 2018). On reflection, perhaps with additional training and a further delay in completion time, Nvivo11 could have been used but I remain convinced that I felt it was necessary to gain an overview of all data and to immerse myself fully in the two sets of data (interview data/field notes from observations and analysis of documentation).

I found that the investigation around professional identity of the research participants, caused me to reflect upon my own professional identity. At the beginning of this journey, I

identified most strongly as a Public Health professional. I had a strong belief in the Public Health opinions of the importance of using statistical evidence for decision making and evidence-based practice. As this study continued and I gained information from different sources, I began to question these opinions. During the analysis and writing up stage of the thesis, this questioning become most acute.

To question the importance of Public Health involvement in licensing was uncomfortable as it felt like I was questioning my own identity as a Public Health professional. It was difficult to reach a conclusion on these issues. If I concluded that Public Health did not have an important role to play within licensing decisions, I would be arguing against the professional group that I primarily identified with and potentially excluding myself from that group. If I concluded that the role of Public Health within licensing decisions was a fundamental requirement of sound licensing decision making, then I felt that I was not accurately reflecting my research findings. My overall conclusion, like my positioning within the research, is that the conclusion was somewhere in the space between (Dwyer and Buckle, 2009). My conclusion was that Public Health cannot completely engage within licensing decisions due to restrictions instigated by national policy, but Public Health are responsible authorities and as such, they can engage in licensing partnerships and claim a legitimate role.

Conclusion of reflective account

There were several learning points during my research journey but my main one is the importance of investigating new ideas and to not simply accept information. The implications of this research for my practice are that I no longer accept that national policy is the 'best' approach to take without consideration of the implications of this policy on the stakeholders and professionals tasked with implementation at a local level. I also feel that I have an increased understanding of the role of individuals within policy implementation at local levels and how whether consciously or unconsciously, professionals can assist or hinder policy implementation. I do feel that my practice has been altered through the completion of this PhD and I feel that this is a change that will continue as I go forward in my career.

Summary

Within this Chapter, the methodology that informed this research study was discussed. This was followed by an outline of the methods used to investigate the involvement of Public Health within alcohol licensing. A discussion followed of the methods of analysis for all data obtained and within the final sections of this Chapter, the issues and limitations that relate to this study were discussed and a reflective account of the research journey was provided.

Within the next Chapter the findings from the research are outlined. The findings have been separated into two parts, namely: 1) review of the SoLP, of each area which was approached to participate in the study and 2) the data from interviews plus field notes from meetings.

5. Findings

Chapter 2 of this thesis outlined the background context that surrounded Public Health involvement in alcohol policy work and alcohol licensing. This described how national policy defined a role for Public Health in decision-making on local licensing and at the same time, shifted the operation of Public Health from a health context to a local authority context. It was left to local authorities and local partnerships around alcohol licensing to develop more specific strategies and approaches to implementing changes and to ensure that Public Health engaged as a new Responsible Authority into the existing licensing partnership. This thesis focused on the implementation process. It considered, from the point of view of those involved in the process, how Public Health responded, and it examined the factors that facilitated and impeded the involvement of Public Health practitioners in licensing.

As a new Responsible Authority, Public Health was entering an established local partnership around alcohol licensing and adjustment to their new role was complicated by the move to a different professional context and a different set of partners. As a result, in looking at how the role developed, it was important to gain an understanding of partnership working in general – the challenges, possible tensions and conflicts which might arise when different groups of practitioners are required to work collaboratively. This was covered in Chapter 3 of the thesis and highlighted several key themes that guided the further design of the study and the interview schedules.

In reporting the findings on the factors that facilitate or impede Public Health engagement in alcohol licensing partnerships, this Chapter uses data obtained from interviews, documentary sources and field notes of observations of meetings. The story is told from the point of view of the interviewees set against insights from local documents and the researcher's field notes completed at meeting observations.

The first section reports the findings from an analysis of a sample of Statement of Licensing Policies (SoLPs). This indicated how local authorities interpreted and translated national policy to the local level and provided some understanding of the context within which Public Health professionals were required to operate.

In the following section, the perceptions and experiences of partnership are considered, including problems of defining what partnership meant and entailed in relation to alcohol licensing. In particular, an examination of the effects of differences and tensions around professional goals and expected outcomes is provided, along with experiences of acquiring adequate and appropriate knowledge to engage in alcohol licensing decisions. In the final section, the implications of differing professional identities on the ability of Public Health to integrate into current partnership arrangements for alcohol licensing is outlined. Specifically, the identity of Public Health professionals is discussed, furthermore, there is consideration of whether this needs to change to ensure engagement with licensing partners.

When Public Health became Responsible Authorities, the policy of localism was provoking a subtle shift in relation to decision making, with local areas gaining increased control over which sections of some national policy to adopt at a local level. Concerning alcohol licensing in London, this meant that the Public Health teams in each borough could increasingly decide on their level of involvement which partially contributed to variable engagement levels across the London region. As one respondent from a regional organisation commented:

“There’s still pockets where they’re not doing anything, they’ve sort of abdicated their responsibilities to licensing, and where they just contribute occasionally. I think there is a frustration that there isn’t more sort of London local guidance, strategic sort of vision and things like that. It is very much left up to the local boroughs, depending on their priorities. It’s not very connected” (R1)

Interview respondents expressed mixed opinions regarding localism, with some Public Health interviewees being supportive of the opportunities that localism afforded whilst others felt that central direction on policy was necessary. One Public Health respondent argued that they felt policy development should occur at a local level with less central government involvement. They said:

“When I moved from the NHS to local government, I didn’t understand about the centralised government that exists and that a lot of what we were trying to use the levers for locally wasn’t possible because of the central nature of policy making. Until the country becomes less

centralised, the local level doesn't have the opportunity to say what kind of community they would like to create in their own boundaries" (PH6).

In relation to alcohol policy however, a system solely reliant on localism could potentially cause problems. For example, if one London borough introduced a Reduce the Strength Scheme or a Minimum Unit Price for alcohol and this became a licensing condition, it was argued that people would simply move their drinking to a neighbouring borough without this policy. Within this research, while some respondents called for policy making at a local level, others argued that policy decisions required to be implemented from a central level.

5.1 SoLPs: setting the local context

The main relevant document for gaining knowledge about licensing processes within each borough is the Statement of Licensing Policy (SoLP). Since the implementation of the Police Reform and Social Responsibility Act of 2011, each borough is required to publish a Statement of Licensing Policy (SoLP) every five years. During the interim period, it is expected that each area will make amendments to the SoLP when necessary. The requirement for each borough to have a SoLP and update these every five years is an example of a national policy, but the influence of local areas is represented by decisions over the exact contents of the SoLP. A generic definition of a SoLP is that it is "A licensing policy statement that details how the licensing authority intends to operate and promote the licensing objectives in their area" (Home Office, 2011). There is a consultation period for each draft SoLP to allow for comments from interested parties such as Responsible Authorities, community groups and members of the public but the finalised document outlines how the licensing authority intends to operate in each area. The SoLP is, therefore, a key document for Public Health practitioners and other interested parties, for obtaining knowledge on the operation of licensing in their borough.

Nationally Public Health organisations, such as Public Health England (PHE), have suggested that one way to increase engagement in licensing decisions is for Public Health teams to ensure that information about their licensing work is included within the SoLP. As indications of both the level of integration of Public Health into licensing and to ascertain if the SoLP contained knowledge pertaining to Public Health, an analysis of a sample of eleven Statement of Licensing Policy (SoLPs) was undertaken. If the SoLP contained a large amount of

information regarding Public Health, partnership working and goals, this could be an indication that the Public Health team in that borough were well integrated within licensing partnerships.

The areas chosen for inclusion in the analysis of SoLPs were all London boroughs, that had been approached to participate in this research. To complete analysis of the document several domains were devised by the researcher. The first domain investigated if there was clear information in the SoLP for the target audience. The second domain examined if Public Health information was included in the document and gauged the amount of Public Health information. For example, did the SoLP outline the health implications of excessive alcohol use within the local area. The third domain asked firstly, if information on partnership working was included and secondly, if an explanation was provided of what this partnership working consisted of in every day practice. The final domain examined if the SoLP mentioned any goals or outcomes from partnership working. If these domains included information around Public Health involvement in licensing decisions, this would demonstrate a degree of Public Health integration – at least at the level of local policy formulation.

The domains were selected based on information gained from the literature review of Public Health involvement in alcohol licensing and partnership working.

5.1.1 Clear information on the target audience for the SoLP

Within the SoLPs examined, whilst each document outlined a specific target audience, such as licence applicants, local councillors, Responsible Authorities and members of the public, the document did not contain all the relevant information that each separate group would need. For example, there was a lack of information on how a member of the public could submit a representation about a licensing application. The information supplied within the SoLPs focused on applying for an alcohol licence, therefore the SoLPs were fundamentally guidance documents. This was evidenced by the contents focusing mainly on process issues.

In two boroughs, it was acknowledged that within the SoLP that there was a conflict of interest between the different target audience groups. This related to balancing local business interests and growing the local economy, with the entitlement of local residents to a safe but vibrant local area. As one SoLP stated:

“The council recognises the wish of local people to live and work in a safe and healthy environment, and the importance of the local economy and community of well-run leisure and entertainment premises” (Borough G).

At a national level, the Home Office stated a SoLP is a policy statement only, which leaves decisions over specific contents, to be taken by local areas and the licensing authority are the editors and authors of each SoLP. There is a requirement to ‘have regard’ to the Section 182 Guidance issued under the Licensing Act of 2003, but exactly what this means is not specified and local boroughs have the authority to deviate from this guidance if this would promote the licensing objectives.

In addition to contents, the language used within the documents was also examined. This aimed to investigate if the document contained barriers, which potentially prevented some audiences from engaging in licensing decisions. Just over half of the SoLPs contained elements of complex language, such as legal terminology and references to acts of parliament within them. For example, reference was made to the Section 182 Guidance issued under the Licensing Act of 2003, without a definition or explanation of this documentation. It was noted however, that the remaining SoLPs contained glossaries explaining terminology and were written in easy to understand, plain English.

5.1.2 Mention of Public Health within SoLPs

In relation to the second domain of Public Health information receiving attention within the SoLP, eight out of the eleven areas mentioned Public Health. In the three remaining areas, one stated that Public Health had been consulted in the preparation of the SoLP, but Public Health was then barely mentioned in the final draft and in the final two areas, Public Health was not mentioned at all, not even in the list of Responsible Authorities who were statutory consultees for licensing applications.

Of the eight boroughs who included Public Health information in their SoLP, the level of prominence within the text varied. In some statements for example, there was an entire section on health, outlining local data on alcohol related health harms. In others, the national alcohol strategy was mentioned, and reference made to Responsible Authority group meetings to discuss applications. The key information that was absent in all of the SoLPs, was the potential roles that Public Health could play in licensing decisions, along with any

indication as to whether Public Health were considered as equal to other responsible authorities. It is important to note however, that there was no information in any SoLP that outlined the roles that any of the Responsible Authorities could undertake. For example, they did not state that the police could work to promote the reduction of crime and disorder objective.

5.1.3 Partnership working addressed in SoLPs

As the number of references to Public Health varied within each SoLP, it was anticipated that the amount of discussion on partnership working would also vary in each area. Five areas had dedicated sections on partnership working, three areas mentioned partnership working but not in any detail and the final three SoLPs did not mention it. Of the areas that mentioned partnership working, there was no detail on how partnership work was evidenced in practice. In two of the SoLPs reference was made to meetings with other Responsible Authorities but it was not clear if Public Health were active participants at these meetings. The information from the SoLPs showed that the exact detail of work taking place was unclear. Whilst partnerships were mentioned within the SoLPs this did not mean, in practice, that collaborative work was occurring.

5.1.4 Outcomes from partnership working

The review of the partnership literature identified the importance of having clearly defined outcomes for successful partnership working. In the review of SoLPs however, no document had any detailed outcomes for licensing partnership work. Three SoLPs did have goals listed which focused on the promotion of the licensing objectives but not on partnership working. Therefore, none of the SoLPs had any in-depth outcomes listed for partnership working and this included work with Public Health. The lack of clear outcomes, it could be argued, presented problems for the different Responsible Authority groups working together in partnership. Table 3 below provides an overview of the results from each area's SoLP.

Table 5: Results of Analysis of the contents of SoLPs³⁹

Area	Clear information for target audience?	Public Health focused content?	Partnership working outlined?	Outcomes of partnership working detailed?	Engagement Level
A	No	Yes	No	No	Medium
B	No	No	Yes	No	Low
C	No	Yes	Yes	No	High
D	No	Yes	Yes	No	Medium
E	No	Yes	Yes	No	Medium
F	No	Yes	Yes/No	No	Low
G	Yes/No	Yes	Yes	No	High
H	Yes/No	Yes	Yes/No	Yes/No	High
I	No	Yes/No	No	No	Medium
J	No	Yes/No	Yes/No	No	High
K	No	No	No	No	High

5.1.5 SoLPs as a gauge of Public Health integration in partnership

To gauge if areas with a SoLP containing large amounts of information on Public Health could be taken as an indication of a greater level of integration within the licensing partnership, a comparison was attempted between each area. This subjective measure was based only on

³⁹ Please note Borough's D and E, G and H, and J and K were combined and covered by one PH department, but each borough had a separate SoLP.

the researcher's judgement of an association between engagement level and extensive documentation of Public Health information within the SoLP.

One area (two London boroughs), which were categorised as highly engaged in licensing, appeared to strongly reflect Public Health and partnership working within their SoLP, however this area had no listed outcomes from partnership work with Public Health. One other area classed as highly engaged, did mention Public Health and partnership working within their SoLP but it was not a prominent feature. The final two areas with high engagement levels, had a SoLP with a minimal mention of Public Health.

Medium engagement areas had sections within their SoLP, discussing partnership work with Public Health but this was not as frequent as some high engagement areas and low engagement areas had even less information about Public Health within their SoLP. It could be proposed therefore, that a loose pattern emerged in relation to level of engagement in an area and the contents of their SoLP.

No area had high engagement levels and a SoLP that reflected a full commitment to Public Health and partnership working with specific, defined outcomes in relation to work around alcohol licensing decisions. One potential cause for this could have related to the timescales around the review of the document with more recently reviewed SoLPs potentially containing a greater amount of information in regard to Public Health.

5.2 Engaging in partnership working

5.2.1 What is a 'partnership' and what is 'partnership working'?

As previously mentioned, the terminology of partnership working in general terms was mentioned commonly in the available literature but precisely what this meant in specific contexts was not easy to identify (see Chapter 3). It was clear however, that partnership working has become the accepted way of working for many professions, including Public Health, with the value of working in partnership not being questioned.

The interviewees were asked about their experiences of partnership work. Although collaboration was promoted as key to licensing work, definitions of what this entailed or how partnerships 'worked' were lacking. Moreover, active engagement in partnerships was

variable and accounts were contradictory – illustrating confusion around how the policy ‘ideal’ on licensing was implemented in practice.

One Public Health interviewee, who attempted to provide a definition of partnership working, said:

“I think it means everybody involved in licensing, working together and having a clear understanding of how we can all work together” (PH4).

The language used in this quote was interesting. This respondent used the words of ‘I think it means’, indicating a level of insecurity regarding the definition. Typically, when respondents were asked to define partnership working, there was a pause before responding. This appeared to be because they had to think, as though they had never been asked for a definition before.

At times however, the information provided during the interviews was not reflected in the partnership working practices reported outside the taped interview. For example, on one occasion, after the interview recording finished, the interviewee explained that they had a disagreement with a licensing colleague and since then they had little contact or involvement within licensing decisions. This was a different impression of the circumstances than the one presented during the taped interview. During the interview, the impression presented was one where despite challenges, partnership working was occurring as this respondent said:

“There is a different relationship with each Responsible Authority group, because we part fund a trading standard post and another environmental health post, I think that relationship is a lot stronger, more collaborative. I think with the police again it’s been a very productive relationship. I would say with licensing, I think that’s probably been more of a challenge and I think at times it doesn’t feel that Public Health is an equal partner” (PH2)

The licensing colleague referred to within the above quote was also interviewed, but they did not mention a disagreement. At other stages during interviews respondents would make comments like ‘this is off the record’ and ‘don’t use this’ which indicated that they were concerned about potential implications of discussing the partners with whom they worked.

There was a dilemma, therefore, in defining partnership, as it may exist at an administrative level but not at a practical level. At an administrative level, the partnership involved all Responsible Authorities and some respondents were positive about partnership working. Licensing professionals, for example, implied that successful partnership working did take place. According to one respondent:

“Well, I think there's a lot of partnership working that goes on most definitely yes. You know the police will do lots of operational visits with various members that can include Public Health, Trading Standards, and our enforcement team. I've worked with the Director of Public Health. So yeah there is collaboration and of course the Responsible Authority meetings that take place” (L1).

Public Health also saw some advances in partnership collaboration:

“I have definitely seen over that time, things move forward. But I think so much of it is to do with not just having the evidence base but about relationships, it takes time to build relationships” (PH7).

This reference to building relationships implied that for partnership working to occur there must be good working relationships between all Responsible Authorities and that this takes time. When this research was completed however, Public Health had been working as Responsible Authorities for a few years. It could be proposed that this amount of time should be adequate to allow the development of relationships within the partnerships, but the reality was somewhat different.

In practice, according to interview accounts and field notes of observations of Licensing Subcommittee meetings, three Responsible Authority groups did not engage – planning, children's services and the fire brigade. When respondents were asked why they thought they did not hear from certain Responsible Authorities, they produced similar answers. In relation to planning, it was stated that the planning department operated under its own legislation and therefore this group did not feel the need to participate as a Responsible Authority within licensing. For children's services, no real reason for the lack of engagement was identified. This lack of involvement from children's services was not limited to the local areas interviewed however as it was also mentioned during an informal meeting with a

representative from a national organisation (N1). As there is a specific licensing objective on protecting children from harm, it was interesting to note this lack of involvement and, among interviewees, it also raised concerns over which Responsible Authority group was representing the interests of children within licensing. As one Public Health respondent commented in relation to the absent Responsible Authority groups:

“There never seems to be any representations or input from them around applications [children’s services]. I think I have seen something from them once when there was an application for an off-licence right next to a school and in an area where there were already several off licenses but other than that nothing and they never come to the licensing forum meetings. Planning also is not heard from but they say they have their own legislation” (PH 7).

In relation to the fire brigade, one suggested reason for their lack of involvement related to restructuring within the Fire Brigade across London. It was reported that there was now only a small centralised team who were charged with responding to licensing applications across London on behalf of the fire brigade. As this was a small team they lacked the resources to become involved in all licensing decisions in each local area.

During the period of fieldwork, varying levels of involvement from the different Responsible Authority groups was observed. Respondents quoted above (L1, PH7) stated that there were Responsible Authority meetings taking place, but within the London boroughs included in this thesis, while two areas reported that they had a Responsible Authorities group, neither of these areas reported that this group was currently active. During the seven months of meeting observations within one borough, where the respondent quoted above (L1) worked, no meetings occurred. In addition, from the observations of the fourteen Licensing Sub-Committee meetings (Area A) during fieldwork, no Public Health professionals attended the meetings; therefore, in that area, Public Health were deemed as not fully engaged within licensing decisions. This information was confirmed during interviews with two local councillors who also stated that there was not a large amount of involvement from Public Health. This opinion on the level of engagement by Public Health within that area in licensing was not shared by the Public Health respondents.

Moving away from local levels, respondents who represented regional and national organisations, all spoke of the 'policy ideal' and advocated for Public Health being involved in partnership working around alcohol. An interviewee from a regional organisation said:

“Where Public Health has good engagement or is being more effective is where they’re working alongside their Responsible Authority colleagues. They’re engaged in the responsible Authority groups, they’re engaged with the councillors, they understand the data and they understand the strengths and the limitations of the data that they have. They’ve also been involved in applying that data to Statement of Licensing Policies and Cumulative Impact Policies and that has then led them to understand how it can be used. They’ve also presented it in a way that is understood by the councils and local authorities” (R1).

The general picture to emerge in relation to partnership working was, therefore, mixed with considerable lack of a clear definition regarding what partnership entailed, coupled with very varying degrees of engagement of different Responsible Authorities and with few attempts to activate Responsible Authority partnership meetings. This was reflected in the discussion around specific aspects of partnership working which are discussed below.

5.2.2 Perceptions of the role of Public Health in the partnership

As far as it was described in the policy literature, the role of the Public Health professional in licensing decisions as previously mentioned in Chapter 2, was “to ensure health bodies are able to act effectively as a Responsible Authority” (Home Office, 2015)⁴⁰ and to “maximise the impact of Public Health within local licensing regimes” (PHE and LGA, 2013). These descriptions within policy documents, provided local boroughs with an outline of the optimal role that Public Health could play within licensing. This research aimed to investigate if this policy ideal had been transferred and incorporated into practice at a local level.

Public Health professionals themselves had different opinions regarding their role in licensing. Responses during interviews ranged from stating that it was a difficult question to answer (PH10) to saying that they did not think Public Health had a specific role as such in licensing (PH4). One Public Health respondent did provide a clear interpretation of their beliefs around their role in licensing decisions. They stated it was:

⁴⁰ <https://www.gov.uk/government/publications/additional-guidance-for-health-bodies-on-exercising-functions>

“to introduce the voice of the trends in alcohol related health harm. I think we hold a lot of interesting data which refers to a local area” (PH7).

The variety of responses received from Public Health professionals regarding their views on their role in licensing did not reflect the ideal definition of involvement which was presented within policy documents.

The licensing professionals interviewed for this thesis spoke positively about Public Health colleagues but seemed to perceive the role of Public Health in a rather restricted way, useful only in some contexts. For example, one licensing respondent (L3) stated that they could not rate the Public Health team highly enough but later during the same interview, this respondent said that the Public Health representations were too generic and as such the Licensing Sub-Committee would not consider them. A different respondent from licensing, spoke about their perception of the potential role for Public Health in licensing partnership work by stating that:

“Where they do come in helpful and handy, is where the local authority has put in place a Cumulative Impact Policy (CIP). Then the information held by Public Health can be used to evidence the reasons for that Cumulative Impact Policy being in place. The health harm figures in an area can be used in that way because it gives a broader picture as opposed to you know, what they can’t do is give the individual picture” (L1).

This implied that the licensing authority in this borough saw a role for Public Health in partnership working but only in relation to providing data for a Cumulative Impact Policy. The language used during this quote was interesting as it referred to Public Health as being ‘helpful and handy’. This kind of description of Public Health did not seem to describe a partner who operated at the same level as their licensing colleagues and had achieved embedding of their role within licensing. However, this potential for supplying useful data and other resources was also mentioned by Public Health respondents as a key element of Public Health contribution to the partnership.

In another area (Borough C), it was stated that Public Health can provide access to data this assisted with successful partnership working. Within this area, the Public Health department

had invested money into licensing work and it was reported that this had assisted greatly.

They stated:

“Putting up money to develop it in the first place and one of the biggest door openers I think with licensing colleagues is access to data. Particularly because I think in our safer community team, they lost one of their analysts, so they don’t have access to any police data anymore” (PH9).

Two respondents from Public Health mentioned using the Public Health budget as a way of improving partnership working. In one borough for example, Public Health were part funding a trading standard post. This seemed to be successful as the post holder worked across two professional groups and as the Public Health budget was used, Public Health was in regular contact with the post holder. This level of contact seemed to ensure that Public Health involvement in licensing decisions remained a priority amongst the different Responsible Authority groups within that borough.

It appears then, that while the ideal role of Public Health in licensing was conceived as an equal partnership between all Responsible Authorities, the Public Health professionals in some local boroughs perceived their role as slightly different. In some boroughs although the Public Health professionals were attempting to achieve the ideal role, in other areas the role was viewed as supportive and around supplying data. The view that Public Health was marginal to decision making on licensing emerged also from discussions around the relevance of Public Health knowledge to licensing.

5.3 The challenges of working in partnership

The study highlighted several challenges in relation to partnership working. In the sections below, three main challenges are reported, which emerged from the data: perceptions of the role of knowledge, working together towards common outcomes and issues surrounding professional identity.

5.3.1 The relevance and adequacy of Public Health knowledge

5.3.1.1 Perceptions of knowledge appropriate to licensing decisions

In considering the role of knowledge acquisition and use, two main dimensions were explored. Firstly, how Public Health professionals acquired knowledge and understanding of

licensing issues, laws and procedures necessary for participation in licensing decisions and secondly, what kinds of knowledge they brought from their own Public Health professional backgrounds and how this was valued and used in the licensing arena.

5.3.1.2 Acquiring relevant knowledge

When Public Health became a Responsible Authority, as this was a new role, several documents and guides to licensing were published and educational events held. The events were organised by organisations such as Safe, Sociable, London Partnership (SSLP) and Public Health England (PHE). These events primarily aimed to provide knowledge on how Public Health could practically engage within licensing decision-making. SSLP were independently commissioned by a few London boroughs to further assist the Public Health team with their licensing processes. Where SSLP was mentioned by interviewees as a main source of relevant knowledge, this was only from areas where SSLP had been specifically contracted to work with Public Health around licensing decisions. SSLP in addition to working within specific boroughs, produced a Public Health alcohol licensing guidance tool. This tool became known as the ‘bullseye’ and it allowed Public Health teams to input a postcode to obtain statistics that could be used in a licensing representation. The SSLP guidance tool was initially only given to areas where SSLP had been contracted to work, but the tool subsequently became shared with Public Health England and distributed more widely. The PHAL (Public Health and Alcohol Licensing) study has recently published a report that includes an exploration of the use of the bullseye tool (Reynolds et al, 2018).

The use of guides to increase knowledge levels around licensing and having the process explained by SSLP was specifically reported by some Public Health respondents as knowledge sources. As one Public Health interviewee reported:

“We commissioned them to do a piece of work [Safer, Social, London Partnership] and they provided a guide for how to use data and how to understand the licensing objectives. It wasn’t formal training, it was guides that I then worked through myself” (PH7).

Most interviewees reported that there was very little formal training undertaken by any Responsible Authority group. In fact, only one respondent from licensing reported having ever undertaken formal training and this was with a professional body, named the Institute of

Licensing. In relation to Public Health, the overall picture that emerged from Public Health interviewees was that no one had undertaken any specific, formal training on licensing. As one Public Health respondent commented:

“No formal training but the data and the process was explained to me by other colleagues and the Safe Sociable London team” (PH2).

Reports that colleagues were the main source for gaining knowledge appeared as a common theme across all Responsible Authority groups. As one interviewee from the police reported:

“Basically, I was trained by the person before me and by Z at the council. There was no official training, there wasn’t in my day” (P1).

Only one group of individuals, who were pivotal in licensing decisions, reported receiving training within local areas prior to involvement in licensing and this was the Councillors who sat on the Licensing Sub-Committee meetings. A former licensing committee councillor who, after completion of training was expected to undertake licensing decisions, said:

“All councillors, before they are able to or allowed to sit on the Licensing Sub-Committee have to undergo some training, usually with the licensing team. It’s a couple of hours dedicated session. But that’s all really. But you can’t sit on the committee until you do that” (C1).

This interviewee reported that the length of the training was very short.

The length of training for councillors was a matter that became part of the discussion of the House of Lords (HoL) Select Committee which reviewed the Licensing Act 2003. One of the recommendations from this review was that the time dedicated to training councillors should be increased (HoL, 2017). The HoL committee argued that current practices around training was not enough to sufficiently equip councillors with the knowledge levels to undertake licensing decisions and suggested a standardised training package for all councillors would ensure uniformity of decision-making⁴¹ (HoL, 2017). According to accounts provided by interviewees for this study, this is not currently in place.

⁴¹ <https://publications.parliament.uk/pa/ld201617/ldselect/ldlicact/146/146.pdf>

From the findings, there were no obvious reasons behind individuals having not undertaken formal training around licensing or, in fact, if formal training was deemed necessary. It was also not clear, that if training in licensing had been available, that this would have altered knowledge levels of the Responsible Authorities or their practice in any way.

In some areas, because Public Health teams had gained knowledge around licensing from written guides, attending events and working with colleagues they felt they could begin engaging in licensing decisions. In other areas, this was not the case and a lack of engagement developed. As a respondent from a national organisation reported:

“If you spoke to Z they’d say that they work really closely with Public Health. There are really good levels of engagement there, but there are still areas where there isn’t. That’s for a multitude of reasons, and I think some of it’s where it’s not seen as a priority, or not seen as an issue and other’s its they don’t know how to engage. I think some of the issues that people have had from the beginning are still there about providing information, but I think as people are engaging they are getting better experience and learning a lot”. (N1)

According to accounts from interviewees there was, therefore, a lack of appropriate and adequate knowledge to provide Public Health professionals (as well as other Responsible Authorities in some cases) with the necessary knowledge foundation to engage effectively in licensing partnerships. This may have generated feelings of role inadequacy, under confidence and hesitancy in participating in decision-making.

5.3.1.3 Public Health knowledge as ‘evidence’

Public Health came to the existing Responsible Authority partnership as a new group with their own body of professional knowledge (this area will be examined in further detail within the section on professional identity). The second dimension of knowledge acquisition and use to emerge from the data related to the status accorded to Public Health knowledge and information, and the extent to which it was regarded as ‘evidence’ appropriate to decision-making in alcohol licensing.

During each interview respondents were asked about evidence use during licensing decisions. There were differences concerning the definition of effective evidence by each Responsible

Authority group and Public Health team’s reliance on statistical data as evidence to inform their practice.

5.3.1.4 What is evidence? Definitional differences

A dictionary definition of evidence is “the availability of facts or information indicating whether a belief or proposition is true or valid” ⁴² (Oxford English Dictionary, 2018). The word ‘evidence’ was widely used within documentation relating to licensing and during interviews held for this research, but what was classed as evidence differed between the Responsible Authorities in different contexts. This demonstrated that there were definitional differences between the Responsible Authorities concerning evidence.

The use of the word evidence implied the operation of a legal system for licensing decisions, but this was not accurate. The idea that licensing operated under a legal system was more commonly used by respondents from the licensing authority, the police and the councillors who sat on the Licensing Sub-Committee meetings, but all Responsible Authority groups commonly used the word evidence. The process of assessing applications and completing review hearings is not a legal procedure. It is only if an applicant appeals a Licensing Sub-Committee decision, that a legal process begins, as this case would be heard by a magistrate’s court. Prior to the Licensing Act of 2003, licensing decisions were undertaken within a magistrate’s court and the continual use of legal terminology and words such as evidence, could potentially relate to this history of a court location for decision making. During one interview the Licensing Sub-Committee was referred to as “quasi-legal” and reference was made to the fact that “if the committee get it wrong it would end up in court” (C2). While licensing is not a legal system and all Responsible Authorities wanted to avoid legal action, there were still elements of legality used with the Licensing Sub-Committee meetings. It was suggested during interviews that, for Public Health individuals to be able to present evidence to the Licensing Sub-Committee, they needed to obtain a good understanding of the legal framework to ensure that they do not make errors regarding the law. As one interviewee commented:

⁴² <https://en.oxforddictionaries.com/definition/evidence>

“I think there is a legal framework, it is aimed to permit, and I think, it has to be quite carefully thought out because it’s all about legislation. I think my worry is that Public Health are going to be just beaten down with the law. I think hopefully what Public Health being a Responsible Authority should do is stop the whole focus on just the legalistic framework” (C1).

The Public Health professionals interviewed, were very clear that the evidence used by them to present at the Licensing Sub-Committee meetings consisted of Public Health data. Examples of Public Health data were alcohol related health harms in a local area, proximity of an application to places where vulnerable people worked or lived and hospital Accident and Emergency admissions. Public Health teams were provided with access to the Public Health Alcohol Licensing Guidance Tool (also known as the Analytical Support Package) which assisted in the identification of relevant data for making representations such as proximity of the application to a school and Local Alcohol Profiles for England data (LAPE, 2018). As the emphasis from national and regional organisations was for Public Health teams to use data labelled as belonging to Public Health within licensing decisions, this was the main approach adopted in local areas.

5.3.1.5 The relevance and adequacy of Public Health data for licensing decisions

After the inclusion of Public Health as a Responsible Authority doubts emerged regarding the role that Public Health could play in licensing decisions. This related to the requirements for health-related evidence to link directly with the premises listed on the application and to one of the licensing objectives (Martineau et al, 2013). The argument that Public Health data was not specific enough for licensing decisions emerged as a theme from the interviews.

Two licensing respondents mentioned generic representations were submitted by Public Health and the committee would not accept them as they did not relate to the exact location of the application (L1, L3). As one interviewee stated:

“If I did have one criticism it would be that the information Public Health provide is too generic. The licensing committee will not take that in account as it is not specific to one premise” (L3).

In addition to the concerns mentioned by licensing respondents, another respondent, a police licensing officer, was also critical of Public Health data as evidence. He said:

“If there’s been a 3.2 percent increase in the last twelve months of alcohol related illnesses for males aged between forty and fifty, how does that reflect on my application to have an extra two hours on my off licence? What are the problems with these males? Where did they get their alcohol from? Are these long-standing problems? What is actually classified as an alcohol related illness? You see what I mean? It’s difficult” (P1).

The debate over Public Health evidence not being premises specific linked with concerns over the weight assigned to Public Health evidence. It was suggested that the Licensing Sub-Committee viewed Public Health evidence as less compelling in comparison to evidence provided by other Responsible Authorities. If it was not premises specific, concerns were voiced about a legal challenge which would potentially incur significant cost to the local authority if they were defeated in court. This was an acute concern due to the current austerity measures being applied from central government during the time over which this thesis was completed. One Public Health respondent talked about the licensing committee’s concerns over a legal challenge by saying:

“whilst I, from a Public Health point of view, feel that the data that we’re providing is weighty enough to change councillors mind, when we’ve actually gone to licensing committee, the comments have been this is all very interesting, but it doesn’t relate to a specific premise and is open to legal challenge. I think there is kind of a general consensus that it is useful and interesting but there is always this spectre of legal challenge behind” (PH7).

The labelling of Public Health data as not specific to premises, provided an example indicating that Public Health did not have the same degree of influence within the licensing partnership in comparison to other Responsible Authorities. One respondent spoke about how evidence from the police was premises specific and was therefore viewed with a greater level of importance. They said:

“I think the Police might come forward and say we’ve got this very specific data and Public Health might have data that supports that, but not as specific. It’s almost seen as that evidential thing because it’s not specific, because from the legal side the more specific information you have that identifies the premise, the kind of higher it’s held up, so if it is just we’ve got area data, it might not be seen as important” (N2).

One interviewee from licensing also spoke about evidence and identified themselves as a gatekeeper in relation to deciding if a representation could be presented to the Licensing Sub-Committee. They said:

“I suppose I am the first gatekeeper to say whether something is acceptable or not from a Responsible Authority. If I then let that through and the committee has it in front of them, then the committee will need to take a view on it. If the applicant’s barrister takes umbrage with the fact that what Public Health says is not sufficient enough related to their client’s venue, then the panel will need to take a view as to whether they thought it was a valid representation or not” (L1).

If the licensing authority in this borough acts as a gatekeeper regarding which representations can be presented to the Licensing Sub-Committee, this indicates the use of power over the other Responsible Authorities. If the local Licensing Sub-Committee decide that Public Health evidence cannot be included, this restricted the access of Public Health to the Licensing Sub-Committee process in that area. Whilst the licensing legislation does not specify that the evidence presented to the committee must be premises specific (Foster, 2016), there is a belief still held that this is the case.

Furthermore, the type of data presented appeared ‘ranked’ in importance by how compelling it was. Actual footage such as CCTV images were viewed as stronger evidence than Public Health data, with these visual images providing a stronger connection with the Licensing Sub-Committee members than statistical information presented by Public Health on for example, the number of assaults within a ward area. During the meeting observations, when CCTV images were presented as evidence, these images of violence and disorder inside premises painted a compelling picture of events that appeared to resonate with the Licensing Sub-Committee members. In one borough a Public Health respondent, reported that they had been told by a Barrister:

“It is personal stories and testimony that the Licensing Sub-Committee pay attention to, not to data and statistics” (PH1).

There was a comment made during one interview that suggested that in addition to consideration around the use of statistical data during Licensing Sub-Committee meetings,

Public Health needed to alter their behaviour to align themselves with licensing by using the correct language. This interviewee said:

“I think what we’re also seeing is while some Public Health teams have really good information, they’re not presenting it in a way that is understood by the council and the Licensing Sub-Committee and they’re not using the language of licensing” (N1).

In addition to concerns over both specificity and strength of the Public Health evidence presented, a third issue about data was identified which related to difficulties with both access to and quality of relevant data. As one Public Health professional, commented during their interview:

“Data that would be really useful such as accident and emergency data, that would create a really powerful case, has been an ongoing challenge not just to us but to other local authorities” (PH2).

This respondent reported issues with obtaining data that became acute due to a lack of a data sharing agreement between the NHS and local authorities when Public Health relocated to local government. The problems with access to data on alcohol related hospital admissions for assaults seems to have persisted and improved access to data in addition was a recommendation for action written in both of the PHE licensing surveys.

To circumvent concerns raised over relevance and accuracy of Public Health data, a potential solution was reported in the interviews. This was suggested to be the submission of a joint representation between Public Health and other Responsible Authorities. In one borough, the licensing authority reported this approach worked better and provided Public Health with a more active role within licensing (L1). This respondent referred to a Trading Standards operation which aimed to target counterfeit alcohol sales. As Public Health could outline the potential negative health impacts from consumption of illicit alcohol, this was described as a good role for them with a direct influence on decisions. A joint representation between Trading Standards and Public Health was subsequently submitted to the Licensing Sub-Committee that resulted in a temporary suspension of the licence (L1).

This suggestion of a requirement for joint representations, raised questions over the nature of the relationships between different Responsible Authority groups, as it suggested that Public Health should adopt a supportive role and not submit representations in isolation. During the observation of Licensing Sb-Committee meetings, there was one joint submission with Public Health, the police and Trading Standards. The Public Health evidence consisted of the number of public order offences which resulted in an ambulance call outs within the ward and the number of schools within 500 metres of the premises, but the main focus of the representation was on non-duty paid counterfeit items that were being sold. At the Licensing Sub-Committee meeting this representation was presented by the police and Trading Standards without a Public Health professional in attendance.

Given the concerns around gaining access to quality Public Health data, along with the concerns about the use of Public Health data as evidence, it could be suggested that the definition of what constituted as Public Health evidence may need to alter to ensure that Public Health professionals can fully participate in licensing decisions.

5.3.1.6 Re-negotiating the definition of 'evidence'

In two London boroughs, the interviewed Public Health representatives mentioned they were attempting to reduce the level of emphasis on using Public Health data as evidence. In one borough, they said:

"My predecessor was quite heavy on the use of data and we've tried to pull that back slightly in terms of actually when you're in the room when it comes to a licensing hearing, it's not about the numbers and confidence intervals, it's about how forceful you make the argument and your professional judgement" (PH 10).

This idea that Public Health should alter their approach to licensing decisions and move away from a reliance on statistical data was mentioned in a separate borough, where they argued:

"In local government, it's all about democracy and politics. You have politicians who you have to convince, hopefully using the data but sometimes it's kind of irrelevant, it's a combination of politics, advocacy, lobbying and data" (PH6).

The above quotes implied that some Public Health departments are concluding that a reliance on data as evidence may not be the best approach for Public Health to adopt at Licensing Sub-Committee meetings. Instead, it was argued that consideration needs to be given to additional influences such as professional judgement, advocacy and the political landscape. During the observation of meetings, data was not commonly used by the other Responsible Authority groups, instead the evidence was based on verbal testimony from Responsible Authorities, witnesses such as members of the public and CCTV images of crime and disorder.

Within this section on knowledge and evidence, the findings centred on slight differences between the main knowledge sources used by each Responsible Authority groups, with Public Health using published guides and a regional organisation in comparison to the other Responsible Authority groups who rely on experience and colleagues. There was little evidence of any formal training, apart from one licensing professional and the local councillors. The training provided for councillors was short. In relation to evidence, differences were found in relation to the type of evidence presented and the weight allocated to each source. Public Health data appeared to be viewed with less value than CCTV images and verbal testimony from Responsible Authorities and members of the public. Given these differences in relation to knowledge, acceptable evidence and positioning within licensing decisions, a complex picture was beginning to emerge around how the different Responsible Authority groups working together within licensing partnerships.

5.4 Working together towards common outcomes

As previously mentioned, health bodies were added to the existing list of Responsible Authorities (along with the licensing authority) in 2011 and in practice the role of Responsible Authority was undertaken by Public Health departments. This decision was taken at a national level and implemented by parliamentary legislation. For Public Health, this was a new role, meaning that in addition to gaining knowledge and engaging with the existing partnership, there would have been a requirement to negotiate the goals and outcomes of their involvement in licensing. Within available literature on working together, the terms goals and outcomes were used interchangeably although each term has a slightly different definition.

The Oxford dictionary definition of a goal is "the object of a person's ambition or effort; an aim or desired result" (Oxford Dictionary, 2018)⁴³ whereas an outcome is defined as "the way a thing turns out, a consequence"⁴⁴. Applying this to the context of this thesis to suggest possible goals for Public Health within licensing, the focus would arguably be on the achievement of a reduction in population level alcohol related health harm. Whilst a possible outcome could be a reduction in alcohol related health harms however, it can be suggested that attributing this outcome as directly due to Public Health involvement in licensing decisions would prove difficult, as there are many other factors that could influence this outcome.

Within the analysis of documentation completed in one borough (area A), for example, the goals for alcohol licensing outlined within the Health and Wellbeing Strategy were listed as, 'review the approach to alcohol licensing decisions', and in the Joint Strategic Needs Assessment (JSNA) the only mention of a goal relating to licensing was the commissioning of an EHO post to work with Public Health on the responsible sale of alcohol. This lack of specific goals however, could have reflected the priority allocated to Public Health involvement within licensing in that particular area.

During the review of literature in Chapter 3, it was documented that outcomes in relation to partnership working were often an under researched area, with any research completed focusing on the processes surrounding joint working. Within the context of this thesis, there were no documented outcomes for partnership working on licensing contained within any of the documents analysed. Any goals that were set consisted of broad statements such as the promotion of the licensing objectives within the SoLPs. The specific detail of exactly what a goal of promotion of the licensing objectives meant was not defined within any documentation and, as the word outcome was not used within documentation, within the remainder of this Chapter the terminology of goals will be used.

During the interviews, respondents were asked about their perceptions of the goals for their involvement within licensing decisions. The initial response from all respondents was to report that they were clear about 'their' goals but over the course of all interviews, it became

⁴³ <https://en.oxforddictionaries.com/definition/goal>

⁴⁴ <https://en.oxforddictionaries.com/definition/outcome>

apparent that the goals differed by professional group. For example, Public Health respondents mentioned goals focusing on reducing alcohol related health harms. The police stated their goal was either the promotion of the licensing objectives or reducing crime and disorder in the Night Time Economy, and the Licensing Sub-Committee councillors stated their goal was to encourage business development balanced with a safe Night Time Economy in their local areas. As one group, the individuals working within the licensing partnership continued to work towards slightly different goals, which could cause issues in relation to which goals took priority and this would weaken the partnership overall.

For some respondents, being questioned in depth about goals forced them to reflect and realise that the overall goals of the partnership were not the same. There was an assumption made that goals were clear to everyone involved in licensing decisions plus they had been jointly agreed, but when respondents were questioned on this subject, a different picture emerged. As one Public Health interviewee said in response to a question on goals being shared across all Responsible Authority groups:

"I'd say it's shared across all Responsible Authorities. I think generally we are all sort of aiming for the same thing, which is safe and responsible alcohol licensing" (PH8).

This statement was then contradicted during the same interview when the respondent said:

"But in terms of work with the Licensing Sub-Committee and the licensing department, you know we work well with them but certainly we're not necessarily working towards the same end" (PH 8).

The one goal most frequently mentioned was the promotion of the licensing objectives. The police, trading standards and the licensing authority all vocalised this as their primary goal. As there is no health-based licensing objective, it could be proposed that Public Health could not fully participate in a goal of the promotion of the licensing objectives with the other Responsible Authority's. One Public Health respondent commented on the fact that they felt the other Responsible Authority groups concentrated on promoting the licensing objectives and this meant that they did not take a wider view on licensing work. They said:

“The vast majority of the Responsible Authority partners are working towards the licensing objectives in a very narrow sense” (PH9).

Although a primary goal of promotion of the licensing objectives was identified across many Responsible Authority groups, each Responsible Authority group had additional goals that were specific to their professional group. For example, the licensing authority had goals on ensuring the promotion of local businesses, the police around community safety and trading standards around reducing the sale of counterfeit alcohol. All the various Responsible Authority groups appeared to share the same broad aim of the responsible retailing of alcohol, but each individual group appeared to have differing ideas and objectives around how to achieve this aim. Public Health respondents did occasionally mention the promotion of the licensing objectives, but their main goals related to health objectives. As one Public Health interviewee stated:

“Public Health, at least in my borough are working to reduce alcohol related health harms so that is a slightly different goal from the other responsible authorities.” (PH4)

Despite each Responsible Authority group having slightly different goals, the commonality of promotion of the licensing objectives as shared by the police, trading standards and the licensing authority provided an indication of the existence of a closer working relationship between these three Responsible Authority groups. One interviewee commented on closer working relationships between certain Responsible Authorities, but it was suggested that this had not formed due to common goal sharing, instead it was attributed to a history of partnership working (PH5). The police, trading standards and the licensing authority had simply worked together more often on projects targeting for example underage sales, which led to these groups spending additional time working together. As this respondent stated:

“The core group are always licensing, the police, environmental health and trading standards they are all very much embedded together and have been for years and years” (PH5)

For Public Health as a new Responsible Authority, this meant attempting to enter into an existing embedded partnership and then attempting to negotiate common goals for joint working with the other Responsible Authorities.

In the literature review on partnership working (see Chapter 3), the importance of setting clear goals that had been agreed by all partners was outlined. Interview respondents within this study were asked if the goals for licensing were jointly agreed amongst all Responsible Authorities and many respondents agreed that the goals were jointly set, with the exception being the Responsible Authorities who did not actively engage within the partnership. As mentioned earlier in this Chapter, these Responsible Authorities were identified as children's services, the planning directorate and the fire brigade. It was reported that these three Responsible Authorities did not often respond to consultations and due to their lack of engagement, they were not involved in setting the goals for the licensing partnership. As one respondent reported:

“goals are shared, maybe not with all responsible authorities as we don't hear from some of them, but they are shared” (L3).

The goals of Public Health involvement in licensing decisions were also investigated during interviews with representatives not based at local levels. The responses received spoke about promoting the licensing objectives and reducing alcohol related health harm. These responses raised the issue of whether a health-based licensing objective was therefore required for Public Health to achieve this goal (this will be discussed in further detail later in this Chapter). It also drew attention to the fact that the goals set at a national level for licensing work, such as the promotion of the licensing objectives, did not always easily transfer into work practices at a local level. One respondent stated that the goals for Public Health should be:

"They should be responding to applications where it's appropriate if there's something about a licensing application that Public Health has something to say on in terms of the licensing objectives then they should be doing that. Public Health should be making sure that the health aspect is considered and where appropriate, represented on, or responded to because otherwise it gets missed" (R1).

Taking a purist view on the promotion of the licensing objectives, it could be suggested that Public Health cannot totally achieve this goal without a health-based licensing objective and therefore a different goal would be necessary. This however places Public Health in a difficult

position in relation to engaging within an existing established partnership, as the overall goals of the partnership are not identical.

5.5 Professional identity and engagement in partnership working

5.5.1 Defining the professional identity of Public Health

Within Chapter 3, definitions of professional identity were outlined and there was a brief discussion concerning a division within Public Health practitioners in relation to alignment with medicine. Each Responsible Authority group involved in licensing will have its own professional identity and the organisation within which the professionals work will also have a unique identity. The inclusion of licensing work within the remit of Public Health will have impacted on the professional identity of this group and arguably the other Responsible Authority groups.

Traditionally, Public Health professionals linked with medicine and all Directors and Consultants in Public Health, who are the senior staff, must obtain accreditation with the Faculty of Public Health (FPH). To obtain accreditation, applicants can either complete a portfolio of practice or obtain a place on a five-year training scheme. The training scheme is closely aligned with medicine as many of the applicants have an undergraduate medical degree, in contrast to the portfolio route with less medically trained applicants. Many DPHs and Consultants in Public Health, who would set the policy direction on Public Health work in local boroughs (including licensing), have a professional identity connected to medicine. As one Public Health interviewee reported:

“I’m a Public Health trainee on the official Public Health training scheme. My background’s medical. I did medicine and psychology then I did two years of junior doctor training, then two years in sexual health care” (PH8).

The managerial professionals within senior Public Health positions therefore have two possible professional backgrounds, either one aligned with medicine or a background that has been suggested to link with the adoption of a wider, more social view of health. The requirements for registration with the FPH to gain employment and for career progression to senior management positions within Public Health are clear. This structure is different to the career progression and employment options for the other Responsible Authority groups, as

there appears to be no specific requirement to be affiliated with a professional body or to undertake training prior to commencing work within licensing decisions.

During the interviews, respondents were asked about education and training undertaken for their current post. This was requested to gain an understanding of which professional group the respondent identified with and to gain insight into any training undertaken around licensing. The Public Health respondents working at a senior level (Consultants or Directors of Public Health) were all members of the Faculty of Public Health. As one of the interviewees stated:

“I’m a consultant in Public Health so I’ve been through the faculty of Public Health national training scheme with the London Deanery. So that’s a four to five-year programme with a Master’s in Public Health and then there’s the professional exams with the Faculty of Public Health” (PH7).

During the interviews, it was suggested by two respondents that professionals with a medical background had a different view of Public Health practice. This related to the professional identity of medical professionals compared to the non-medical staff. The first interviewee said:

“A lot of Directors of Public Health come from the medical profession and see themselves on a different level and they don’t communicate very well with other people. Whereas we find the assistant Director of Public Health, who has not a medical background is a much easier person to deal with or sees the broader issues much better” (PH5)

A second interviewee also spoke about medical identity compared to non-medical, which they related to the social determinants of health. This respondent felt that alcohol licensing was part of the social determinants of health model. They said:

“There’s the social determinants of health model of Public Health and there’s the medical model of Public Health. A lot of these Directors of Public Health are medics. So, I’m not saying they can’t be interested in the social determinants of health, but it might take a bit more to get them interested” (PH6)

In addition to allegations of a division within Public Health professionals over identity relating to medicine or to social determinants of health, there was the assertion that Public Health professionals working on alcohol licensing decisions did not have much experience of alcohol policy work prior to involvement in licensing decisions. Before the transfer of Public Health to local councils, alcohol policy work was undertaken in boroughs by teams named Drug and Alcohol Action Teams (DAATs). DAATs consisted of practitioners with differing areas of expertise around addiction policy. As mentioned within Chapter 2, the reconfiguration of the NHS, which included the transfer of Public Health to local authorities, resulted in some DAATs being disbanded with staff being made redundant, re-deployed or absorbed into Public Health teams. In areas where DAAT teams were dismantled, Public Health professionals obtained responsibility for alcohol policy work arguably without the experience and knowledge of the DAAT teams. One interviewee reported:

“From experience with Public Health, they’ve had very little background to do with alcohol. I worked with Public Health before transition and tobacco and health checks were the main issues that they were involved in. Pandemic flu outbreaks needed to be prepared for, but I don’t think I have ever been involved in any kind of alcohol meeting with Public Health” (PH5).

This respondent’s background was Environmental Health and Health and Safety, but they had been tasked with responding on behalf of Public Health to licensing applications, due to the Public Health department declining involvement within licensing decisions.

5.5.2 Organisational identity and Public Health

To gain an understanding of any impact on professional identity that the relocation from the NHS to local authorities had introduced to Public Health professionals, interviewees were asked about their views on the move to local authorities, with a second question asking, whether their opinion had changed over time. The views reported on the move initially focused on the opportunities that being part of the local council would bring and Public Health respondents reporting that the move to local government would allow an expansion of focus from a health-based model, to a wider systems model including the social determinants of health. As one Public Health interviewee stated:

“I thought moving into the local authority would help us around the wider determinants of health. The local authority is involved in things like housing, sanitation stuff like that which

ties in a lot with what influences the public's health. In that way, it was a good thing to have that freedom to be based and to work with colleagues who do that sort of work" (PH4)

Local authorities had historically been the location where Public Health was based, and Public Health departments only became part of the NHS during the 1970s. One respondent, in addition to arguing that the move would provide increased opportunities to influence the wider determinants of health, argued that the move back to local authorities was where Public Health belonged. They said:

"I've always thought that Public Health should have been in the local authority anyway. That's sort of just where it should be. When you're going for the wider determinants of health the NHS isn't where it's happening really" (PH3).

The quotes in relation to the geographical location of Public Health departments, appear to reflect an idea that the location of the profession influences the views held and in the case of Public Health, the approach to health. For example, when Public Health were part of the NHS the focus was argued to be on health and health care but within a local authority setting, it is argued that Public Health can focus on the wider determinants of health. The second question, which asked if opinion had changed as time had passed, found the respondents from Public Health were beginning to report negative experiences post transition. One respondent who initially had been positive about the move reported they now thought Public Health should have remained part of the NHS. They said:

"There are times when I think perhaps we should have stayed in the NHS. It's probably a very bad time to come across, a lot of local authorities and this one included are taking the Public Health budget to fund activities, which you can argue (but only if you really tried) would be treating the health and well-being of the local population. But they're not really Public Health. Public Health being everything and anything is too wide in a sense because the budget is being raided" (PH 3).

Public Health initially transferred to local authorities with a protected ring-fenced budget whilst local councils were enduring budget reductions from central government. Local authorities were eager to gain access to the additional resource of Public Health budgets and one option to achieve this was to reassign existing work as a Public Health project. Public

Health respondents in addition, were concerned about their budget being targeted once the protection of the ring fence was removed.

While speaking about moving to local authorities, one Public Health respondent spoke about the different organisational culture in local government. They commented that:

“If you’ve been working for twenty or thirty years in the NHS and suddenly you’re put into a much more politicised context, where you have elected members and a whole different system of governance and a whole different organisational culture, that’s always going to be very difficult. I think if anything even I was surprised by how much disruption and distraction the move has caused. We just go from reconfiguration to reconfiguration, so I mean there’s no space to actually do anything” (PH10).

If the move to local authorities caused disruption as this quote suggested, it could be proposed that Public Health professionals may have been reluctant to embrace a new role within licensing as they were already dealing with a change to their professional identity initiated by the move to local government. One Public Health respondent reported confusion over the specific role of Public Health professionals after the transfer to local authorities was completed. They said:

“You know people sort of struggle to understand exactly what it is that Public Health does. A lot of time they sort of said to us ‘oh you are environmental health’ and that was just the understanding of Public Health” (PH4).

If professionals working within local councils were not clear over the remit of Public Health departments, this confusion could, over time, have an impact on the professional identity of the Public Health practitioners. One Public Health respondent suggested that the move led to a crisis of identity for Public Health professionals. This interviewee said:

“I think it’s been very problematic. I think, there are broader problems across Public Health in terms of what I would describe as an existential crisis. You know, what is the value, what is the purpose, what is the point of Public Health?” (PH10)

It was clear from the interviews that the transition of Public Health to local authorities created disruption for Public Health professionals. As professional identity takes time to

develop, it could be suggested that Public Health professionals would require time to learn the necessary skills for working within local councils and in licensing decisions. After transition and commencing work as a Responsible Authority, this new role with licensing decisions would also have affected their professional identity.

5.6 Public Health as a Responsible Authority

Whilst Public Health were adjusting to their new location within local authorities, they were also working within licensing decisions and during each interview respondents were asked about their views on the addition of Public Health as a Responsible Authority. Overall, most Public Health respondents felt it was useful to be a Responsible Authority, but there were concerns raised regarding how successful it had been in practice. One Public Health respondent proposed that the other Responsible Authorities knew that Public Health lacked knowledge initially within licensing decisions. They said:

“I think initially because all the Responsible Authorities had been doing this work for a long time and we were these new people who didn’t quite know what we were meant to be doing. You know they felt maybe we weren’t quite sure” (PH4).

Whilst Public Health were mostly positive about their role in licensing, this opinion was not shared by all Responsible Authorities interviewed. For example, one respondent from licensing commented:

“In terms of Public Health, initially I just thought well what were they going to be doing? Having had the act already up and running and things going on, I just didn’t see how Public Health were going to be able to play into the process really” (L1).

In another borough, a licensing professional commented that the addition of Public Health as a Responsible Authority was good on paper, but in practice it was not successful (L3). This lack of success was attributed to the absence of a health-based licensing objective, along with confusion over the remit of Public Health within licensing (L3). One respondent simply commented:

“I didn’t really have an opinion as it didn’t impact on me personally” (P1)

While the opinions on the addition of Public Health as a Responsible Authority were mixed, with Public Health professionals positive about the addition and other Responsible Authority groups being less so, a respondent from an organisation which worked across London, only spoke positively about Public Health becoming a Responsible Authority. They said:

“I think the addition of Public Health as a Responsible Authority was a very, very good thing to happen. Clearly health needs to be considered in licensing and I think it reflects an increasing understanding by the government that alcohol is a health issue as well as a sort of crime disorder, anti-social behaviour violence issue, but that it had a real health aspect to it”. (R1)

For this respondent, it was important that Public Health work on licensing reflected the perceived changing opinion of national government regarding the health impacts of alcohol. A respondent from a national organisation spoke differently about the addition of Public Health as a Responsible Authority. They said they had completed work in local areas that attempted to proactively engage Licensing Sub-Committees with the idea that Public Health were a useful addition to the list of Responsible Authorities. This work had only been partially successful, but they also argued that Public Health professionals needed to alter the language used as this did not fit with the organisation. They commented:

“I think Public Health also had to learn the language of the council, which I think some areas struggled with. I think there’s a lot of Public Health teams having to change, so they’re still talking about Public Health issues, but they have to speak it in a language and in a way, that’s understood by the council and then links into council priorities.” (N1)

The idea that Public Health need to change behaviour in relation to the language that is understood by the council, linked with an earlier point regarding Public Health viewing themselves as scientific and using terminology, such as alcohol attributable fractions, within presentations. The use of scientific language whilst part of the professional identity of Public Health, could be suggested as a factor that would be unknown to the other Responsible Authorities and the councillors on the Licensing Sub-Committee. The respondent who suggested that the language used needed to be changed also spoke about the impact of the addition of Public Health as a Responsible Authority on the professional identity of the other Responsible Authorities. They argued that the addition of Public Health was important as this

allowed the development of an overall picture of alcohol issues within an area and this, they argued, encouraged other Responsible Authorities to view licensing not purely as a street level process of assessing applications. They stated:

“It allows that connection between population at street level and the move away from looking at licensing purely as an administrative business process and more as strategic, a tool for looking at how do we want our living spaces and communities to look, and I think bringing Public Health in has allowed for a bit of a shift in the way licensing does it” (N1).

5.6.1 Role legitimisation of Public Health as Responsible Authorities

The transition of Public Health to local authorities and the introduction of Public Health as Responsible Authorities occurred prior to the commencement of this study and thus time has elapsed during which Public Health professionals could have developed role legitimisation within licensing. Part of this research examined if the inclusion of Public Health as a Responsible Authority had become legitimate. Public Health have had an opportunity to gain both knowledge and experience in licensing decisions and from interviews, it seems that Public Health had reservations about becoming involved in licensing. As one respondent stated:

“I think I was fairly sceptical about the role of Public Health in licensing to begin with. I think I am more confident now that actually this is something that we should be doing” (PH10)

This respondent felt that the inclusion of Public Health as a Responsible Authority was now legitimate. Another respondent from Public Health also suggested that Public Health have a legitimate role to play in licensing decisions. They commented:

“Now it’s validated. I think you know having capital letters, Responsible Authority and having a place round the table and being able to comment, being able to go to licensing meetings, I think that’s been really helpful. Actually, having a role, not just kind of jumping up and down from the back, but actually being sat at the table” (PH7)

Some respondents spoke about how it had taken time for Public Health to embed in the role of Responsible Authority and how relocating to a local authority setting had assisted in legitimising the licensing role. As one respondent commented:

“I think the major change, that was the beneficial change, was the fact that because we were part of the local authority we become more embedded and we’re seen as kind of actually being within an organisation rather than working in partnership with an organisation. Organisationally, there have been more opportunities I think, to embed Public Health across the system” (PH12)

Other respondents spoke about how their role was legitimised by points such as having licensing work evidenced in the Health and Wellbeing Strategy (H&WBS), being aware of future plans and developing their own strategies for alcohol licensing work. As one interviewee stated:

“We have the vision defined, we have evidence in our strategy and we know the direction of travel we’re going in” (PH2).

This opinion that Public Health’s role in licensing was legitimate was not universal across all Public Health respondents however. In one of the interview areas, the Public Health respondent felt that their contribution to licensing decisions was not as valid as other Responsible Authorities. They stated:

“Theoretically we’ve got the same say as every other Responsible Authority. But it doesn’t feel like that still. I mean it doesn’t matter if you go on training and lawyers tell you that and I don’t know if it is just because the licensing objectives don’t have health or whether it’s something more than that” (PH1)

The opinions expressed by a respondent from a national organisation, was firmly that the role of Public Health in licensing decisions was legitimate. This respondent argued that Public Health had to expand on their engagement within licensing decisions to validate their involvement. They argued:

“I think maybe particularly more engagement, it legitimises Public Health, they’ll be seen less as a supportive Responsible Authority and more Responsible Authority in their own right. Some of those arguments and myths that have come up will go, but you will still find that there will be Public Health teams who will take this role and run with it and see themselves as a full responsible authority” (N1)

The quotes relating to legitimisation of the role of Public Health as a Responsible Authority, appear to show slight differences between national and local levels. The respondent from a national organisation felt that the role was completely legitimate whereas in the local areas, this opinion is weaker, and it seems to have taken time for professionals to gain legitimacy over the role of Responsible Authority.

5.6.2 Health As a Licensing Objective (HALO)

The requirement for the introduction of a fifth licensing objective focusing on health and well-being was an issue that was frequently mentioned during interviews. Within the published literature reviewed for this study, there was also a large amount of debate regarding the potential need for a fifth licensing objective. For example, a Local Government Association (2016) survey found that 89% of Directors of Public Health stated that they felt there was demand for a health-based licensing objective within their council area. This statistic was argued to be misleading however due to the low response rates to this survey from all regions of England (House of Lords, 2017)

A fifth licencing objective based on health was allocated the acronym of HALO or Health As a Licensing Objective. Due to the level of support at a national level for health as a licensing objective, an assumption could be made that local areas would also share this view, but within this research, that was not found to be the case. As one Public Health respondent argued:

“I know there’s a huge push to put Public Health in as one of the core licensing objectives but if it fits in very well with the other core areas, protection of children, nuisance, protection of public safety and so on. Do we need one in its own right? I’m not sure. I see it as that evaluation of information, bringing all the strands together rather than to deal with one licensing objective” (PH5)

This respondent argued that decisions relating to licensing applications, should not be purely based on the licensing objectives, instead consideration of a wide range of factors was required. In another area, the Public Health respondent felt that while it would be good to have a health-based objective, they had managed to engage within licensing decisions without it. They stated:

“I think it’s limited by not having the objective relating to Public Health, but I actually also think that we’ve circumnavigated that quite well here. When I first arrived, I found the fact that we didn’t have a specific Public Health objective quite hard. It took a while to figure out how we can influence without having an objective to fall back on” (PH11)

The Public Health respondents who argued that Health As a Licensing Objective was necessary, spoke about its establishment as a way of increasing their power within licensing decisions. Comments were made such as:

“I think it would give us a much stronger seat at the table. Having a fifth licensing objective can’t fail to help give us a bit more weight and be seen a bit more as an equal partner. You know particularly because if there was a fifth objective around health, then health data would have to be a primary consideration, because you can’t have a licensing objective without any kind of weight behind it” (PH7).

Within the local areas included in this research, the Public Health interviewees felt that while overall it would be useful to have health as a licensing objective, it was not essential for engagement within licensing. At a regional and national level, the respondents interviewed all argued for the introduction of health as a licensing objective. The interviewees from two national organisations were fully in favour of the introduction of a health-based licensing objective. The first respondent argued that without this, Public Health did not have much power to affect change. They suggested:

“I just do feel a bit as if they’re kind of fiddling around at the edges, making some difference, but not the difference that it potentially could make if licensing was properly a health objective and you could make representations based on, you know either saturation as a health impact or whatever to make it more in line with the situation as in Scotland”. (N2)

The respondent from a second national organisation was also fully supportive, they stated:

“This would fundamentally change what they can do, and I think there’s probably more recognition that what Public Health can do is confined to the licensing objectives and therefore, that is quite limited. I think Health As a Licensing Objective is the thing that should be sought if

they really want to make more of a local impact to health and inequalities through licensing, that would be the way to do it. Absolutely”. (N2)

At times during interviews respondents from regional and national organisations expressed a different view point in comparison to the interviewees in local boroughs. This was most evident in the conversations around Health As a Licensing Objective with full support behind the necessity of the introduction of a health-based licensing objective at the national level but in the local boroughs, although it was described as useful to have a fifth health-based objective, it was not deemed essential. Local areas claimed to have developed work practices to compensate for not having Health As a Licensing Objective. Any decisions over the licensing objectives, including development and implementation of a health focused licensing objective would be taken at the national level, with a requirement for a legislative change if implementation was felt necessary. Currently, there are no indications that a health and wellbeing licensing objective will be introduced in England. In Scotland, where there is already a Public Health licensing objective, there are documented ongoing issues with operationalising the objective (AFS, 2017). It could be proposed that this situation in Scotland, impacts on the likelihood that health as a licensing objective will be introduced in England.

5.6.3 Is Professional identity a barrier to working together

As previously mentioned, each Responsible Authority group has its own professional identity that develops over time based on experiences. Given the various Responsible Authority group involved in licensing have separate professional identities, this raises questions over whether this would represent a barrier to working together in partnership. One respondent from a regional organisation provided an example of Responsible Authorities preventing Public Health from becoming involved in licensing decisions. They stated:

“There are areas where there’s been resistance to inclusion. There’re certainly areas in which Public Health is only involved when licensing decides that they should be involved. There are other times where licensing and the police don’t work particularly well with Public Health, so you don’t get joined up work” (R1).

This example provides an illustration of difficulties encountered by Public Health in attempts to engage with other Responsible Authorities. If one partner is not prepared to work with other

groups, the partnership may fail before it is established. Another interviewee discussed barriers to engagement, but these were ascribed to Public Health presenting information that the police felt belonged to their professional group. They said:

“Where there’s an objective that says crime and disorder and the police have the main lead for this. What you see, is when Public Health presents this information, there are pushbacks from others, and particularly from the legal side” (N1).

This implied that information presented by Public Health to the Licensing Sub-Committee was expected to be their own data and there should be no presentation of information regarding crime and disorder as this infringes upon the professional identity and remit of the police Responsible Authority. In a separate borough, the professional identity of each Responsible Authority group was suggested to impact on their approach to licensing, which was suggested as a reason for no collaboration. This respondent said:

“The other issue would be that environmental health, health and safety, planning and trading standards they’d be looking at it from a very different perspective. If they have an issue, it would be a very different issue from what we have so there wouldn’t necessarily be the reason for that collaboration there” (PH8).

In this context, it was suggested that working within different frameworks was a barrier to partnership working and it prevented different Responsible Authorities from discussing licensing applications with each other. It was not known if the lack of collaboration was instigated by Public Health themselves, or by the other Responsible Authorities mentioned above but the overall picture that emerged was one of confusion.

Public Health was given the additional role of working as a Responsible Authority and this would have an impact on their professional identity. During the interviews with Public Health respondents for this study, it was presented that each Responsible Authority group had continued to work within their own professional framework, which represented a barrier to working together on licensing. One Public Health respondent, for example, described their relationships with other Responsible Authorities as a series of marriages of convenience and stated that it was going to take some time for them to be fully integrated with the other

Responsible Authorities (PH 11). This respondent went on to state in relation to other council departments that:

“I just don’t think that we actually communicate with the rest of the council much. I think we’ve made really good progress with the licensing team but in terms of what I observe with other people it’s quite segregated. I just feel like they’re a bunch of silos” (PH11).

The allegations of Responsible Authorities only working within their own framework was not limited to the other Responsible Authority groups involved in licensing, it was suggested that Public Health professionals also only worked within their professional group. As one respondent commented:

“I think Public Health still see themselves, it’s a bit strange isn’t it, as medical and clinical, they don’t see themselves as involved in legislation or regulatory. We still have this battle” (PH5)

Another respondent suggested that the professional identity of Public Health set them apart from the other Responsible Authorities and the approach to acceptable evidence was part of this. During the interviews, this Public Health professional said:

“The purist idea that we would have as epidemiologists and as scientists about evidence and the way we would conceptualise evidence, is quite different to the more persuasive and advocate-based approach that one might take from a licensing point of view” (PH10).

This quote stated the professional identity of Public Health incorporated a view that they were scientists, which is a different identity to the other Responsible Authority groups that Public Health engaged with within licensing. The implications of this quote are that if Public Health felt separate from the other Responsible Authority groups, this could lead to the situation where instead of Public Health being excluded by the other Responsible Authorities, Public Health were in fact self-excluding themselves from licensing work. In one area in the sample for this study, the Public Health department reported no involvement in alcohol licensing. This decision had been taken by the Public Health department themselves and did not appear to be due to any form of exclusion by the licensing authority or any other Responsible Authority group. In this area, the licensing authority reported actively trying to

engage with the Public Health department, but the Public Health team had not become involved.

While in some areas, professional identity appeared to present a barrier to engagement in partnership working, in two areas individuals emerged who described extending their professional boundaries to foster increased involvement within licensing work. As one Public Health respondent stated:

“I’m a bit of a person who works across boundaries and pushes people, a bit less corporate maybe” (PH 6).

The idea of working across boundaries in order to address factors labelled as the wider determinants of health, had been cited as a positive reason for Public Health’s move into local authorities. Now this idea appeared to be expanding to include Public Health utilising their role as a Responsible Authority within licensing. For Public Health to become embedded within licensing work, it could be suggested that to establish partnership working arrangements with new partners would involve working across the professional boundaries of different groups.

In another area, an interviewee argued that collaboration between all Responsible Authorities was essential, regardless of individual professional identity. This respondent said:

“I would see licensing and Public Health pushing it together now. We’ve got to be seen as one group, I think ‘them and us’ are gone, so it’s one authority, its one council” (PH5)

This was an interesting comment as this respondent had recently been allocated responsibility for Public Health licensing work, but their background was not within Public Health. Their knowledge and experiences were based in environmental health and health and safety. Due to their own professional background containing different experiences and ideology, perhaps this individual found it easier to work across different groups.

As there were examples of individuals who were attempting to work across boundaries within this study, it could be proposed that these individuals appear to have a greater level of flexibility within their professional identity and they were prepared to evolve over time to add new professional roles such as licensing.

5.7 Summary

This Findings Chapter began by outlining how the SoLP is the main document within each area that outlined the working practices within licensing. The review of the SoLPs, showed that in some boroughs there was a focus on Public Health work in licensing, but overall further work was needed to fully integrate the work of Public Health in licensing within this document. Partnership working was suggested as key for the successful inclusion of Public Health within licensing decisions at a national level, but there were several issues identified within current partnership arrangements. These related to a lack of a clear definition of partnership working in licensing, with confusion over the goals of the partnership and no set outcomes. Closer working relationships between the different Responsible Authority groups was argued as beneficial for improved collaboration but this was compromised by barriers arising from differing professional identities of each Responsible Authority group and allegations of professionals working only within their own professional frameworks and in silos. There were also indications that Public Health were excluded from licensing decisions in some areas by their Responsible Authority partners and in other boroughs there is a suggestion that it was Public Health themselves who were self-excluding from licensing work.

The issue of evidence featured strongly in the interviews with questions raised over the legal framework under which licensing appears to operate, the definition of acceptable evidence and whether Public Health are a marginal Responsible Authority due in part to the evidence they present in representations. At a national level, Public Health were presented with a vision of the 'ideal' role within licensing, but this has not translated into practice in all local areas. In some boroughs, there were signs that the role of Public Health was seen as valid, with professionals suggesting that Public Health should be included within licensing. In other boroughs, this was not the case and Public Health professionals felt that they were unable to fully participate in licensing decisions. At a national level, it was suggested that Health As a Licensing Objective was necessary to increase engagement, but at the local level, it was felt that although a health-based licensing objective would be a useful addition for Public Health, it was not essential. This illustrated a gap between national and local areas regarding vision and policy on alcohol licensing.

In the next Chapter, the points raised above will be discussed in detail with a specific focus on the implementation of national policy on alcohol licensing at a local level. There will also be a discussion on how partnerships are viewed as the mechanism for the delivery of policy and how the barriers and enablers identified within this Chapter impact on this process. Public Health needed to establish themselves as a Responsible Authority within an existing partnership and the implications of this will be outlined in the next Chapter. The findings from this study will also be related to the theoretical concepts mentioned earlier in this thesis (see Chapter 4) and draw on the existing literature on alcohol licensing.

6. Discussion

Since the 1970s there has been increasing interest in the involvement of Public Health within alcohol policy work. The situation began with the growing assertion that alcohol consumption affected the entire population of the United Kingdom and not purely a minority who drank to excess (Berridge, 2013). As Public Health departments are tasked with improving population health, and alcohol was increasingly argued as impacting on this, Public Health bodies at a national level became engaged in alcohol policy development and implementation. This involvement was strengthened by the addition of health bodies as Responsible Authorities (RAs), a measure introduced by the Police Reform and Social Responsibility Act (2011). Due to the reorganisation of the National Health Service (NHS) which included the abolition of PCTs, Directors of Public Health (DPHs) were tasked with a role in alcohol licensing decisions. Shortly after DPH took on the new role as Responsible Authorities, Public Health departments were faced with a major re-organisation of the NHS, which included the transfer of Public Health departments from the NHS to local authorities. Public Health professionals, therefore, needed to quickly learn and adapt to new work responsibilities, coupled with working with colleagues with different professional identities from themselves. The result within London boroughs was that variable levels of engagement developed regarding licensing.

Within this research, the findings demonstrated a complex picture emerging around partnership working, acceptable evidence, knowledge and identity. There was also a specific focus on how national alcohol licensing policy was interpreted and implemented in a sample of areas across London. The research was qualitative in design, incorporating semi-structured interviews, along with documentary analysis and observation of Licensing Sub-Committee meetings over a seven-month period. The specific research questions were:

1. How is national policy around the role of Public Health in alcohol licensing translated and implemented at a local authority level?
2. What are the factors that facilitate or impede Public Health engagement in alcohol licensing partnerships?

To ensure that the two research questions outlined above were fully answered, during this Discussion Chapter the findings from this research are related to available literature on policy implementation, partnership working and professional and organisational identity.

6.1 Key themes

The analysis of data produced from fieldwork produced a number of findings and these were outlined in Chapter 6. There is no intention within this Chapter to include a large amount of further detail relating to these, instead as a summary, the key findings have been grouped together under two key themes and these were:

- The role of Public Health within licensing decisions
- Engagement and Challenges to licensing partnerships

6.2 The role of Public Health within licensing decisions

In this section, political and contextual factors, nationally and across the region of London, that impacted on the role of Public Health within licensing during the completion of this research, are outlined. The policy process is briefly discussed, and this is related to the research findings. The impact of the policy of localism on Public Health involvement in licensing decisions is discussed along with an examination of the confusion and lack of clarity over the roles played by Public Health professionals within licensing. Partnership working has become established as the fundamental way of working within Public Health and as each licensing application is reviewed by a group of professionals named Responsible Authorities, partnership working can be viewed as an essential element of licensing work.

6.2.1 Political and policy context 2014-2017

Buse et al (2012, pp7) point out that “you cannot divorce politics from policy” and as the first research question for this study centred on national alcohol policy translation and implementation, politics requires examination. Applying this quote to this study, prior to an examination of specific policy, the political context and alterations that occurred during the completion of this thesis are outlined. This research began in October 2014 and politically since this date, the national government has altered from a coalition, consisting of representatives from the political parties of the Conservatives and the Liberal Democrats, to a solely Conservative party government. During 2017, due to a snap election called by the

Prime Minister, an unexpected result has meant that the UK is now governed again by a confidence and supply agreement⁴⁵ consisting of the Conservative party and a few MPs from the Democratic Unionist Party (DUP). Over this period, it has been a time of political uncertainty, with referendums on membership of the European Union and whether Scotland could leave the United Kingdom union. All these political changes can be suggested to have had an impact on policy decisions. The European Union referendum result, to exit the EU, which was termed as Brexit, has meant that the current political focus rests on negotiating the UK's exit from the EU which is due for completion during 2019.

This changing political situation can be argued to have impacted on the policy process around alcohol. The last national alcohol strategy was produced in 2012 and only recently an announcement was made that a new national strategy outlining alcohol policy direction, will be produced in the short-term future. A national Drugs Strategy was published in 2017 (HM Government, 2017), but there were few mentions of alcohol policy within this document. It can be suggested, that the current political focus on Brexit, along with changes to national government has meant that strategic alcohol policy formation, including around licensing, is not currently an area receiving a large amount of attention. For example, during 2017 a House of Lords Select Committee⁴⁶ review spent six months obtaining evidence from witnesses to produce a report on the Licensing Act (2003) (HoL, 2017). The report included several recommendations, including one which argued that licensing decisions in the future should be brought under the remit of planning departments.

A response from government was received⁴⁷ (HM government, 2017), presented to parliament and debated. The government view in response to the Select Committee's assertion that the Licensing Act (2003) required a complete overhaul was that "the government does not intend to be hasty in instigating such an overhaul of the Act" (HM Government 2017, p8). The government suggested that, instead, they would implement recommendations that would help to improve the working of the existing act, such as better training for Licensing Sub-Committee members and amending the guidance issued under section 182 of the Licensing Act (2003) (HM Government, 2017).

⁴⁵ <https://www.bbc.co.uk/news/election-2017-40245514>

⁴⁶ <http://www.parliament.uk/licensing-act-committee>

⁴⁷ http://www.parliament.uk/documents/lords-committees/Licensing-Act-2003/Govt_Response_Licensing_Act.pdf

A second political factor, which has impacted on the policy process, is budgetary reductions introduced as austerity measures by national government. Local authorities have faced significant cuts to their budget during the past few years. Public Health departments initially transferred to local authorities with a ring-fenced budget but as councils were experiencing budget reductions, Public Health budgets were a potential source of additional funds. Within this research, the Public Health respondents reported that their budget was being used for projects that were not specifically Public Health work. Since 2015 there have been reductions in the budget allocated to Public Health from central government, known as the Public Health grant and this can be suggested to have led to a reduction in Public Health staff. With fewer professionals employed, Public Health departments have had to prioritise which areas of work receive attention, including the reportedly time-consuming alcohol licensing work.

6.2.2 Politics and policy context across London

Briefly looking at alterations to the policy context across the geographical area of London, there have been subtle changes emerging that are influencing policy direction around alcohol licensing. The first of these was the appointment in 2016 of a Night Czar for London. The successful candidate was Amy Lamé, who has a background in both television/radio and in nightclubs in London. The Local Government Association (LGA) website stated that Lamé is “at the very heart of the conversation about venues under threat of closure in London”⁴⁸ (GLA, 2018). In addition to this appointment, the Mayor of London and the Greater London Assembly are promoting London as a 24-hour city that is always open for business. The webpage about the night czar speaks of how there is “an increased demand for a broader night-time culture and entertainment offer” (GLA, 2018). Part of this new approach includes looking at the promotion of the Night Time Economy and alcohol licensing will be an integral part of this policy. The London Mayor has also created a Night Time Commission, who aim to “bring local authorities, businesses, police, residents and workers together to shape our plans” (GLA, 2017, p18).

A new draft London Plan has also recently been released for consultation. Within this document, requests for local areas to balance promoting the Night Time Economy with the

⁴⁸ <https://www.london.gov.uk/people/mayoral/amy-lame>

cumulative impact of high concentrations of licensed premises were outlined⁴⁹ (GLA, 2017). The draft London plan suggests that there was an expectation that local areas will perform a balancing act between local businesses and residents. Point 7.6.2 in the plan states, “The Mayor is keen to promote London as a 24-hour global city, taking advantage of London’s competitive edge and attractiveness for businesses and people looking to expand beyond the usual daytime economy into night-time economic opportunities. However, 24-hour activities are not suitable for every part of London and its residents, and boroughs should balance the needs of local residents with the economic benefits of promoting a Night-Time Economy” (GLA, 2017, p293).

The appointment of a night czar, a Night Time Commission and the draft London Plan encouraging the promotion of London as a twenty-four-hour city, represents a shift in alcohol policy across London towards increasing activities within the Night Time Economy (NTE). Although the London Plan suggests that a balance can be achieved between the needs of residents and the economic benefits that a bigger NTE can bring to an area, it could be suggested that in times of austerity, economic benefits could carry more weight than the needs of local residents. At the time of writing, consultations on the London plan are ongoing, therefore final decisions have not been made. The draft London plan does however present local boroughs with a complex balancing act. As Public Health are tasked with improving the health of the population however, this subtle shift in policy across London could be viewed as an opportunity for Public Health professionals to further engage with local residents around licensing decisions, to ensure that the health and wellbeing of local residents are represented within licensing decisions.

The national and regional policy context around alcohol will affect the role of Public Health within licensing decisions. Public Health will need to monitor developments in regional alcohol policy to maintain their position within licensing decisions amid this changing context.

6.2.3 Health policy development and implementation

In the previous section, the contextual issues that influenced policy processes were outlined. As the role of Public Health within licensing decisions is primarily dictated by national policy

⁴⁹ <https://www.london.gov.uk/what-we-do/planning/london-plan/new-london-plan/draft-new-london-plan/Chapter-7-heritage-and-culture/policy-hc6-supporting-night-time-economy>

development and implementation, within this section literature on policy development is discussed and related to the findings from this research. During completion of this study, Public Health respondents voiced confusion over their role within licensing and other respondents noted that, although Public Health were given the statutory right to become a Responsible Authority by national legislation, local professionals working within licensing voiced mixed opinions over the inclusion of Public Health as Responsible Authorities. This was an example of an implementation gap between national policy and local level practice (Buse et al, 2012). Hallsworth et al (2011) reporting findings from a study on civil servants in London, concluded that there was a gap in policy making between theory and practice, which led to unrealistic models of policy making or a failure to provide support to turn a policy into reality. Hallsworth et al (2011, p5) suggested that this meant “civil servants often know what they should be doing but struggled to put this into practice”. Elements of this situation appeared within this study where, in some areas, individuals were aware of the addition of Public Health as a Responsible Authority but still did not seem to know how Public Health would be able to fully participate in licensing decisions. As the licensing authority in area A said, *“I just didn’t see how Public Health were going to be able to play into the process really”* (L1).

A related concept to an implementation gap, was whether policy development should be top down (developed centrally and distributed to local areas) or bottom up (developed locally, grows in popularity and becomes adopted centrally) (Buse et al, 2012). Discussions relating to the most appropriate process for policy development will continue after the completion of this thesis, but specifically within this study, opinion was divided. Some Public Health respondents felt there was need for greater involvement in licensing policy from central organisations, such as national government and Public Health England (PHE), whilst other respondents valued the policy of localism, which allowed them to make limited licensing policy decisions within their own areas.

6.2.4 The impact of localism

The policy of localism and the Localism Act⁵⁰, marked a shift in decision making from central government to local areas across the UK. In some areas, localism has grown into requests for devolved powers for decision making. The region of London is no exception to this and there are devolution projects ongoing, including one prevention pilot on licensing. In London, therefore, there has been a slight shift towards allowing some policy to be developed at a local level.

In relation to Public Health involvement in licensing, each London area made decisions in relation to their level of engagement. The option to disengage was available and some areas did adopt this approach as can be observed in area B within this research. In this area the reasons for the lack of engagement in licensing were provided as poor data quality, lack of support from elected members, and a Public Health respondent even stated that there were no alcohol issues within their area.

An interesting development in discussions around localism recently arose in a report on licensing from Scotland (Alcohol Focus Scotland (AFS), 2017). Within this report there was a recommendation that a national licensing policy should be developed, suggesting that in Scotland there may be a return to a centralised approach to policy making around licensing. The report by AFS (2017) suggested that a national approach should be adopted to overcome inconsistencies between policy and practice. It will be interesting to observe firstly, if this approach materialises in Scotland and secondly, if a similar return towards nationalised policy development and implementation around licensing decisions is adopted in England. During the completion of this study, whilst there were no calls for a national policy on alcohol licensing, at a regional level an alcohol policy for the London region was suggested to be a good idea (R1).

6.2.5 What is the specific role of Public Health within licensing?

Whilst discussions continue over policy processes and the best location for policy development within local areas, Public Health professionals continue to engage within licensing decisions and attempt to make improvements in their level of involvement in some

⁵⁰ <http://www.legislation.gov.uk/ukpga/2011/20/contents/enacted>

areas. The role of Responsible Authority for Public Health, however, appears to be continually affected by a lack of a clear definition of the implications of this role. Within available documentation the role of Public Health within licensing was stated as “to act effectively as a Responsible Authority” (Home Office, 2015) and to “maximise the impact of Public Health within local licensing regimes” (PHE and LGA, 2013). What exactly this meant in practical terms at a local level was difficult to define. For example: Does the definition of an effective Responsible Authority refer to reviewing every licensing application or is it submitting representations on relevant applications received only? A similar comment could be levelled at the above definition of ‘maximising Public Health impact’ as, in practical terms, it is not clear what this means.

Without a clear definition of the role of Public Health in alcohol licensing within the central policy literature, it is not unexpected that Public Health professionals at the local level experience difficulties in operationalising their role. This confusion was expressed during interviews where, although Public Health professionals could clearly outline the potential roles for Public Health within licensing, this potential was not always realised within local areas. For example, in area A, the Public Health respondents were clear regarding explanations of their potential role in licensing, but on a practical level this potential was not being achieved. In this area despite talking about the importance of attending the Licensing Sub-Committee meetings, there was a lack of Public Health presence at Licensing Sub-Committee meetings and little contact between the different Responsible Authority groups. This was one local area, where there was clearly a gap between the policy ideal and practice.

As previously mentioned within this study, the Statement of Licensing Policy (SoLP) was the main document that outlined the procedures that the licensing authority in each borough would follow. National organisations such as PHE, have suggested that Public Health should ensure that they are included in the SoLP as this will increase their involvement in licensing decisions. Within the eleven SoLPs reviewed for this thesis however, although a very loose pattern emerged in relation to Public Health engagement in licensing and the contents of the SoLP, overall no area had a SoLP that clearly outlined the role of Public Health within licensing decisions. In addition, no borough had a SoLP that reflected a full commitment to partnership working, with specific defined outcomes in relation to work around alcohol licensing. This

lack of detail within the SoLP around Public Health's role within licensing, can be seen to be an indication of the lack of clarity over the role that Public Health should play.

It is important to mention that even if a Responsible Authority group had a clearly defined role to play within licensing, this does not always correlate with the practical role that these professionals played. Three Responsible Authority groups were identified as falling into a 'mostly inactive' category and these were children's services, the planning department and the fire brigade. In relation to the planning directorate and children's services, there was no involvement in licensing decisions observed during fieldwork, but this was not new information to emerge. Within the available literature, it was documented that planning departments operated under their own regulatory regimes and therefore did not engage within licensing decisions (Home Office, 2017). The House of Lords Select Committee report on the Licensing Act (2003) (Home Office, 2017), recommended that this situation should not be allowed to prevail, but during the recent debate on this report within parliament, no amalgamation of planning with the licensing authority was opted for (Home Office, 2017). The draft London plan also promotes "Management of the Night Time Economy through an integrated approach to planning and licensing" (GLA, 2017, p292) but it remains to be seen how this integration will be implemented.

At the beginning of this study in a meeting with a key informant from a national body, the lack of involvement from children's services within licensing was mentioned as a concern (N1). This remains an intriguing situation, especially as there is a licensing objective specifically focused on the prevention of harm to children and it also raises questions over who ensures that the rights of children are represented within the current licensing regime. This could be suggested as an area requiring further research to ascertain possible reasons for this situation. The other Responsible Authority group identified during this study as having a reduced level of engagement within licensing decisions was the fire brigade. Like children's services and planning, the fire brigade has a clear role within licensing decisions in relation to fire risk assessments on new applications. During this study a respondent from area B, reported that due to funding reductions to the fire brigade, there was only a small centralised team that processed all licensing applications that required input (PH5).

As some Responsible Authorities were actively engaged in licensing decisions, whilst others are not, it could be suggested that this could set a precedent for Public Health. It meant that although Public Health are statutory Responsible Authorities, this does not necessarily mean that involvement with licensing decisions was required. If there were already Responsible Authority groups who did not engage, despite being statutory consultees on licensing applications and there were no sanctions regarding this, then Public Health could also assume that there would be no sanctions for non-participation.

To integrate within the existing licensing partnerships within boroughs, Public Health may have begun by working in partnership with the other Responsible Authorities by using the common ground shared by all partners however, Public Health and the other Responsible Authority groups have a range of competing demands placed upon their time. Hunter and Perkins (2014, pxi) referred to this competition as “contested spaces”. Public Health professionals do not only work on licensing decisions as licensing is only one responsibility within a range of potential roles that each Public Health practitioner can play. The contested space referred to the fact that the potential roles within Public Health work were varied and ranged from global pandemic prevention, immunisations, epidemiology to alcohol prevention work (Hunter and Perkins, 2014). Given the range of roles that Public Health professionals can adopt, it was argued that these professionals worked in a space that was contested in relation to priorities and work streams (Hunter and Perkins, 2014). Hunter and Perkins (2014) proposed that this contested space presented challenges in relation to the attainment of an overriding definition of the contents of Public Health work. The addition of Public Health as a Responsible Authority within licensing was an additional role for Public Health practitioners within an already contested space. This new role had to vie with other priorities within local areas and it required additional resource commitments to ensure continued participation. It could be proposed that in some boroughs, for example areas with large NTE, matched with higher than average alcohol related crime and disorder figures, greater weight would have been placed on Public Health involvement in alcohol licensing decisions.

The space within which Public Health operated was not the only contested space within licensing partnerships however as the various Responsible Authority groups also compete within licensing decisions for their work area to gain priority and resources. For example, the police may feel that their role within licensing should be a priority due to the connection with

reducing crime and disorder whereas Trading Standards may feel their role is crucial as it involves preventing public nuisance. For Public Health professionals then, there are two contested spaces to navigate, one within their own professional group and one within the role of a Responsible Authority involved in licensing work. The impact of contested spaces, suggests that Public Health professionals working within licensing, would adopt a co-ordinating approach within licensing partnership work (Snape and Stewart, 1996).

Confusion over the role of Public Health in licensing decisions was also apparent from the opinions expressed by a proportion of respondents from other Responsible Authority groups. In relation to a definition of the role of Public Health within licensing, opinion was split over whether this should be a supportive role and therefore subservient to other Responsible Authorities or if Public Health should have equality with other Responsible Authorities. This was evident in area A, where the role outlined for Public Health was one of support and of supplying data. If Public Health were viewed as only being able to play a supportive role in licensing decisions that could equate to Public Health being viewed as marginal in relation to decision making. Stapleton (1998, p33) when discussing collaborative practice in healthcare, proposed that “to facilitate genuine participation and joint decision making, relationships need to be recognised as interdependent and non-hierarchical in nature”. If Public Health are being viewed as supportive and marginal decision makers, this does not facilitate their inclusion within licensing. The proposal that Public Health should be accorded the same status as other Responsible Authorities related to equality and this was raised as an enabling factor for partnerships within the available literature (Wildridge et al, 2004). The equality centred on all partners being viewed as equally valid about opinions (Gambetta, 2000) and equality in relation to power (Stapleton, 1998, Wildridge et al, 2004, Glasby and Dickinson, 2009). If Public Health are adopting a supportive role within licensing decisions, this implies that they are not viewed with equality and command less power in decision making in comparison to the other Responsible Authorities.

Within this section it has been reported that there is a lack of clarity and confusion over the potential roles for Public Health professionals within licensing decisions. This confusion can be suggested to have led to a situation where Public Health as a Responsible Authority, have had difficulties in operationalising their role within licensing at a local level and this contrasts to the policy ideal presented at a national level. There were also tensions over whether Public

Health should be a supportive Responsible Authority or be equal with other Responsible Authority groups, along with variations in engagement in licensing by each Responsible Authority group.

6.3 Engagement and challenges to Public Health in partnership working in licensing

Health bodies were added to the list of Responsible Authorities in 2011 (along with the licensing authority) and subsequently Public Health began undertaking this role within licensing partnerships. Within this section the enabling factors and barriers to Public Health partnership working in licensing, which emerged within the findings from this research are discussed, along with an examination of the finding that some Public Health professionals felt that they had obtained role legitimacy (Shaw et al, 1978). As previously outlined in Chapter 3 partnership working was the recommended approach to addressing the complex and long-term problems called 'wicked issues' (Rittel and Webber, 1973). Excessive alcohol use is an example of a wicked issue, with Public Health involvement in alcohol licensing aiming to address excessive alcohol use through measures to control alcohol availability. Partnership working was presented within guidance documents to Public Health professionals as the 'ideal' approach to licensing work. In the literature review for this research however, it was noted that overall there was little evidence of the effectiveness of partnership working (Glasby and Dickinson, 2008). Specifically, in relation to partnership working around alcohol policy, Thom et al (2012) concluded that there was a lack of evidence of effectiveness and clarity over which elements of partnership working provided added value. Given the issues with health partnerships, it is intriguing that this remains the approach advocated for work around alcohol.

6.3.1 Definition of partnership

Like confusion around defining the role of Public Health within licensing, there was confusion over the definition of 'partnership'. This is not a new issue, as there have been difficulties for several years (See Leathard, 1994, Ling, 2000 and Banks, 2002). Within the available literature there were a number of different proposals for 'types' of partnership as described in Chapter 3. Snape and Stewart (cited in Powell et al, 2006, p306) proposed 3 types of partnership and named these as facilitating, coordinating and implementing.

Applying this model to licensing partnerships, initially it appeared that Public Health would want to establish a facilitating partnership within licensing. Consideration of an implementing approach to licensing, would not be applicable as this work is neither time limited nor is it a mutually beneficial project. During this research however, the partnership type used within licensing appeared to be a more co-ordinating approach, with consideration of other pressing priorities within the contested space of Public Health work. The adoption of this approach provides an example of a difference between policy at a local and national level. At a national level within documentation it was suggested that Public Health have a facilitating role in partnerships, but at the local level within this study, a co-ordinating approach was taken. It could be proposed that it would be useful to identify the precise type that licensing partnerships identify with, as this could assist to dispel part of the confusion over licensing partnerships.

Within this research, at times within the local areas, there was a gap between belief systems around partnership working and the practice observed at a local level. This was demonstrated by individuals reporting that partnership working was the policy ideal but, at the local level, integrating into an existing partnership with established relationships was not achievable. This left Public Health with a decision over whether to continue to attempt to become embedded within the existing partnership or whether to accept that the role was not sustainable and withdraw. The most notable example was in area A, where the Public Health professionals spoke about how important partnership working was within licensing but then it became apparent in relation to behaviour that there was actually very little contact between Public Health and the licensing authority.

6.3.2 Partnership goals and outcomes

In addition to a lack of research into partnership work generally, there was also a lack of research into the specific area of Public Health partnerships (Hunter and Perkins, 2014). In the available literature it was noted that most of the limited research on Public Health partnerships focused on the process of partnership working with little attention being allocated to the goals of the partnership (Dickinson and Glasby, 2010). Dickinson and Glasby (2010) emphasised in addition, that the focus on defining goals was misplaced as defining outcomes for the partnership was of greater importance (Dickinson and Glasby (2010).

Within this research, there were no defined outcomes for licensing partnership working. Whilst there were goals defined, these varied by professional group. A lack of agreement and clarity over goals was mentioned as a barrier to effective partnership working by some authors and McQuaid (2009) argued that in some situations, this could cause partnership failure. In this research Public Health professionals were primarily working towards a goal of improving Public Health. The licensing authority, the police and trading standards primarily shared a goal of the promotion of the licensing objectives. These three Responsible Authority groups had a shared history of working closely together over joint operations, such as under age sales and counterfeit alcohol. As these groups had closer working relationships and shared a goal, it could be proposed that these groups achieved a better level of partnership working arrangements. Public Health could perhaps over time build a shared history with these partners in licensing, but additional steps would need to be taken to allow Public Health to share the same goals as the other licensing Responsible Authorities. Whilst different goals may not lead to a failure of the overall partnership in relation to Public Health involvement in licensing, it can be proposed that it could cause issues relating to which goal takes priority. During this research, it emerged from the data that it was not apparent to each individual Responsible Authority group, that the other Responsible Authorities had slightly different goals from them. It appeared that the goals and outcomes for partnership work around licensing had not been discussed prior to the formation of the partnership.

The fact that a goal of promotion of the licensing objectives was set at a national level as the goal of licensing practice, was an example of a policy implementation gap at local levels. Public Health cannot commit to working towards a goal of the promotion of the licensing objectives as there is not a health and well-being-based licensing objective. This added complications for Public Health to engage with the other Responsible Authorities within the licensing process.

6.3.3 Health As a Licensing Objective (HALO)

In relation to goals, the most commonly mentioned goal by respondents within this research was promotion of the licensing objectives. As there is no health-based licensing objective, it can be proposed that Public Health would be unable to have this as their goal in licensing work, which potentially places Public Health at a disadvantage in relation to engaging within

licensing partnerships. There have been calls for the addition of a fifth health-based licensing objective and there already is a Public Health objective in use in Scotland. Within this research however at local levels, it was felt that health as a licensing objective would be useful to assist with licensing representations, but it was not essential. Some local Public Health interviewees (PH7 and PH10) felt that they had developed measures to compensate for the absence of a health-based licensing objective. Respondents at a national/regional level however, emphasized the benefits that health as a licensing objective could bring to Public Health involvement in licensing.

The implications around health as a licensing objective from this research were two-fold. One was this was an example of a difference in opinion between respondents from national/regional organisations and local levels. The decision over any introduction of an additional licensing objective would be taken at a national level, as this would require a legislative change, but it would be the local level professionals who would be tasked with implementing this policy change. If this change was not completely supported, this could have consequences regarding policy implementation.

There is already a health and wellbeing-based licensing objective in Scotland, but a recent study on licensing concluded that despite having this objective, issues with implementation remain (AFS, 2017). As the recent report by Alcohol Focus Scotland (2017, p12) commented, "Promotion of the Public Health objective is inconsistent and continues to be contentious".

The second implication of health as a licensing objective related to the finding within this research that Public Health professionals stated that a focus on only licensing objectives was too narrow a view to take. Some Public Health respondents felt that a wider view, i.e. not purely focusing on the promotion of the existing four licensing objectives was necessary. It was proposed that Public Health were restricted by this type of licensing system as this partially prevented the inclusion of Public Health data. If the approach taken allowed for inclusion of all evidence from outside of the licensing objectives, such as increases in the number of individuals with alcohol dependency within an area, this could be suggested as allowing an easier system for the inclusion of Public Health evidence on the impacts of alcohol on local level population health.

6.4 Factors enabling partnership work

Partnership working is not a straightforward process and despite little evidence of added value from this approach it continues to be viewed as the main mechanism for health policy delivery. Before discussing the points identified within this study as enabling factors within licensing partnerships, it is important to mention that in some areas in London, partnership working around licensing appears to operate well. There are boroughs that appear to have Public Health professionals fully participating within licensing decisions. This statement can be made due to these areas having established strong links with academic institutions, national and regional organisations such as Public Health England and Safe, Sociable London Partnership, along with visibility in publishing research papers relating to licensing within their area and London as a whole. There were a few common features identifiable in areas that appear to have achieved a greater level of participation in licensing decisions and these were areas with a larger than average Night Time Economy (NTE) with visible problems around excessive alcohol consumption, who also had dedicated resources to licensing and who had at least one senior individual in the Public Health department who was motivated around increasing Public Health participation within licensing decisions. During the interviews, data emerged which corroborated these factors as enablers. For example, in area A, it was reported that resources had been spent on a post within environmental health that worked around Public Health objectives for licensing and in area C, where there were saturation issues in certain areas that linked with alcohol related crime and disorder, the Director of Public Health had become involved to resolve the problems.

Within the available literature there were authors who outlined success criteria for partnerships (Wildridge et al, 2004; Crawford, 1997; Gambetta, 1998; Powell et al, 2001, Thom et al 2011, Hudson et al, 1999, McQuaid, 2009). Using the criteria outlined by Thom et al (2011) as this related to the implementation of alcohol policy and relating this to this thesis produced the following points for discussion. The first criteria in Thom et al's (2011) work spoke of building a tradition of partnership working. As previously mentioned within the current arrangements around licensing and Public Health, although Public Health has a tradition of working with partners, this appears to have not occurred in all boroughs on licensing. There is a tradition of partnership working between some Responsible Authority groups and this is most notable between the licensing authority, the police and trading

standards. It emerged within this research, that these Responsible Authorities have a shared history of working together around alcohol licensing and Public Health are attempting to become imbedded within this.

The second point was to be flexible (Thom et al, 2011). This was evident in some areas included in this research, where the Public Health professionals reported shifting their approach to licensing decisions. This shift included moving away from a reliance on Public Health statistical data towards for example, attempting to agree borough wide regulated opening hours and sets of standardised conditions for each application. The third criterion related to obtaining buy in and appointing champions (Thom et al, 2011), which again, using data from this research, was occurring in some areas (areas A and C). There was a second point relating to this, which was the importance of replacing champions when they left the organisation. Without the champion, the motivation to continue working around licensing can be lost, especially in the contested space of Public Health work. The fourth detail was to define clear roles and responsibilities (Thom et al, 2011). In addition to this point, it could be argued that it is vital to set goals (or preferably outcomes) jointly for the entire partnership to share. This research found confusion over the goals of the licensing partnership and although respondents were clear about 'their' goals (based on professional group), there was no agreed overall goal for the partnership work. This system allowed each Responsible Authority group to work towards slightly different goals and this could be a barrier within a fully functioning partnership.

Building trust and breaking down professional silos have also been proposed as key for partnership working (Thom et al, 2011). Within this research, in the areas with increased involvement of Public Health in licensing decisions certain factors were in place. This linked to Public Health staff working across professional boundaries and establishing opportunities to work closer with other Responsible Authorities, such as setting up Responsible Authority meetings to discuss applications or physically sitting with the licensing team for part of the working day. Thom et al (2011) also suggested that good communication was an enabling factor within partnerships.

In the London boroughs used as part of the sample for this research, communication was variable. In some areas, there was a lack of opportunity for good communication as the

Responsible Authority groups did not meet in person to discuss applications (area A). In other areas, although no specific issues relating to partnership working were mentioned during interviews, using data obtained from field notes and analysis of documentation, it was apparent that issues existed between different partners. This was based on a lack of attendance at Licensing Sub-Committee meetings by some Responsible Authority groups and a lack of clear information, for example within the SoLP, on the role that each Responsible Authority group played within licensing. Finally, Thom et al (2011) pointed to the importance of demonstrating gains. Again, this was a factor that was being implemented in some boroughs but not in others. For example, in area D, interviewees spoke about how they felt they were making progress and had been successful in some Licensing Sub-Committee meetings. Within this research, some areas had engaged with the licensing authority and proactively set up a partnership group for discussing licensing applications (area C). This became the forum for each Responsible Authority to inform the other attendees about gains achieved. Applying these factors to this research showed that in some boroughs these elements were in place and being used, but this was not the case across all areas.

6.5 Challenges to partnership work

The main challenges to partnership work around licensing, emerged to be the absence of the enabling factors outlined above. When these factors were missing, the partnership did not work effectively. Specifically, in relation to this research, two additional themes became apparent in relation to partnership working. These were issues relating to what constituted acceptable evidence within licensing decisions and what was regarded as adequate knowledge. The theme of acceptable evidence overlapped with issues of professional identity and this is discussed in full detail later in this Chapter. In relation to adequate knowledge this related to differences between professional group identity, which sources of knowledge were allocated higher value and how Public Health professionals obtained an adequate level of knowledge around licensing.

6.5.1 Acceptable evidence

In relation to Public Health involvement in alcohol licensing decisions, there were two main points to be made regarding the word evidence. The first point connected with the use of evidence within policy making and the second related to the evidence that was viewed as

acceptable within licensing. Turning to the first point, previous research on policy processes stated that policy makers “do not make systematic use of evidence in their work for a number of (now familiar) reasons” (Maybin, 2016, p2). Maybin (2016, p2) argued that these reasons related to “academics took too long to produce evidence for policy makers who are working to deadlines, research is inaccessible, the findings do not easily translate into policy and there are cultural differences between researchers and policy makers”. Relating this to this study, the first point for discussion was the question over whether there was evidence that the addition of Public Health as a Responsible Authority was a policy change that would bring substantial benefit to population health in relation to alcohol. There was no evaluation built into this policy implementation and therefore, evidence of the impact of this policy is absent. Prior to the addition of Public Health as a Responsible Authority, there had been no research completed for policy makers about the potential outcomes that this policy would produce. This demonstrates a lack of evidence for the policy introduction and given the assertion that Public Health work is evidence based, raises questions over the decision to add Public Health as a Responsible Authority.

A second point regarding evidence was there were differences in relation to the contents of acceptable evidence assigned by the various Responsible Authority groups. This also related to professional identity and Public Health being reliant on evidence-based practice. Within this study, Public Health professionals were clear during interviews in stating that their evidence was Public Health data and no respondents mentioned the use of case law for example when participating in licensing decisions. Public Health reliance on statistical data as evidence presented Public Health with issues, both in relation to the belief that health-related evidence had to link directly with the premise listed on the application and to one of the four current licensing objectives (Martineau, 2013). The finding that Public Health evidence was viewed as less compelling than evidence submitted by other Responsible Authorities and the labelling of Public Health data as not specific enough (not premises specific) represented large obstacles for Public Health to overcome to effectively engage within licensing decisions. The label on submitted evidence related to different Responsible Authorities working within their own professional frameworks.

Despite national organisations providing evidence in support of the conclusion that the Licensing Act (2003) does not specify that information must be premises specific (Foster,

2016). As Foster (2016, p12) stated “there is nothing in the Act, Section 182 Guidance or case law that directly underpins the ‘premises by premises’ approach”. Within this study however, it was found that there remains a belief that Public Health evidence is not specific enough for inclusion in licensing decisions. This opinion was compounded in one area where the licensing authority reported that they acted as ‘gatekeepers’ regarding whether a submission was acceptable or not (area A).

In addition to the allegation that Public Health evidence lacked specificity, was the claim that Public Health representations were less compelling. It was argued that this was due to the format and language used within Public Health representations. Primarily, it was suggested that Public Health presented statistical information, and this was less well received by the Licensing Sub-Committee than police evidence such as CCTV images detailing crime and disorder. The Licensing Sub-Committee councillors are not Public Health specialists with backgrounds in statistics or epidemiology. They are local civilians, with an interest in serving their communities and therefore the presentation of complex statistical information could be a barrier to Public Health engagement in licensing. To alter this, Public Health may need to change the language and style used within their representations to fully engage with the members of the Licensing Sub-Committee. For example, one respondent argued that consideration should be given to professional judgement, advocacy and the political landscape instead of a reliance on statistical data (PH10).

Difficulties with access to Public Health data were also mentioned during this thesis and this was raised as an issue within PHE licensing surveys in both 2015 and 2016. Issues with access to data were compounded by the transition to local authorities when a lack of robust data sharing agreements caused issues between the NHS and local authorities. This can be stated as an area that requires improvement, especially if Public Health continue to rely on data as evidence. As already mentioned, the inclusion of licensing case law on Public Health England’s website may be a recognition of a necessity to alter the underlying definition of Public Health evidence.

6.5.2 Adequate knowledge

This research examined both sources of knowledge and training undertaken around licensing. It discovered that very little formal training was undertaken by any Responsible Authority

group and that colleagues were the main source of knowledge. The only group required to undertake any form of training prior to involvement in licensing were the councillors and this training was very short. There was no standardisation in the training provided and therefore it can be suggested that the quality of the training was likely to be variable. As previously mentioned the training of councillors was highlighted during the recent House of Lords select committee review of the Licensing Act (2003) (House of Lords, 2017).

Although Public Health reported using a guide to licensing, a general theme emerged within this study around learning being primarily completed from other colleagues and this generated questions over the ability of colleagues to impart their embodied knowledge (Freeman and Sturdy, 2015) to others. Within this study, Public Health professionals seemed to learn about participation in licensing decisions from experiential sources. There were examples of trial and error, where a representation would be submitted, and Public Health would await a decision over whether it would be presented to the committee or if the licensing authority would act as gate keeper and reject the representation. This provided an example of Public Health enacting their embodied knowledge and potentially gaining new knowledge through the process of participating within the Licensing Sub-Committee meeting (Freeman and Sturdy, 2015). The Licensing Sub-Committee meetings were the location, where knowledge around licensing policy was enacted. If Public Health were not in attendance at these meetings, it would be difficult to ascertain how Public Health gained knowledge around the practicalities of licensing decisions.

Without the acquisition of adequate knowledge around licensing, this could lead Public Health to feel both underconfident and hesitant in relation to participation in licensing decisions. This could in turn, contribute to feelings of role inadequacy and insecurity (Shaw et al, 1978). Even in the scenario where Public Health had received training on licensing, in practical situations this training may have left Public Health unable to equate this training to real life situations. Although arguably this situation could have resolved as time progressed and Public Health gained knowledge, in this research it appears to have not altered in all areas. Respondents, although not reporting role inadequacy, did appear to lack confidence in relation to responding to applications. An example of this was area B, where the licensing authority reported meeting with Public Health to provide advice and training on how they

could input into licensing decisions but despite this, Public Health involvement in licensing remained minimal.

Historically as the licensing system operated for several years without any involvement from Public Health professionals, this new role for Public Health as a Responsible Authority, may not have been a responsibility that Public Health professionals felt confidence in claiming as their own. Licensing partnerships had functioned satisfactorily without input from Public Health. Anecdotally, from personal experience within a Public Health department, there was little support around the role that Public Health could play within licensing, unless a regional organisation such as SSLP were commissioned to assist. After Public Health became Responsible Authorities individual Public Health team members, who were interested in licensing decisions, began work to discover the potential roles within licensing. Although the DPH was the named person as the Responsible Authority, it became the responsibility of a lower level team member to review applications, submit representations and attend Licensing Sub-Committee hearings. Within this research, it was argued that the move of Public Health from the NHS to local councils was one factor that assisted in making the role of Public Health within licensing decisions valid. It was argued that being based in the same organisation as the other Responsible Authorities, having licensing work in the health and well-being strategy and being aware of future plans, all validated the role of Public Health within licensing decisions. This opinion was not universal across all boroughs, however, as in some areas it was felt that Public Health should play a supportive role with other Responsible Authorities (L1).

The issues of role adequacy, role legitimacy and role support also linked with professional identity. Once a new role has been accepted as legitimate, such as a Responsible Authority within licensing decisions, the identity of the profession should alter to absorb this new role. It could be proposed that Public Health involvement in licensing has not reached this point to date in all areas across London, which could be contributing to the varying levels of engagement.

6.6 The impact of professional identity on the ability to work in partnership

The addition of Public Health as Responsible Authorities and the transfer to local government from the NHS would have impacted on the professional identity of Public Health

professionals, with Public Health bringing their historical professional identity background into licensing. Whilst closer working relationships between the different Responsible Authority groups would be beneficial for partnership working, it could be argued that this process would be affected by obstacles arising from differing professional identities. Within this study there were allegations of professionals only working within their own professional frameworks and in silos. Public Health attempted to enter into an established licensing partnership as a new group with their own body of professional knowledge. As mentioned earlier in this Chapter, there were issues around the status given to Public Health knowledge and over what constituted as acceptable 'evidence' for licensing decisions.

Taking a historical view of licensing, there is a long tradition of legality and legal system involvement. To a certain extent the influence of the legal system is maintained today. Magistrates' courts no longer make decisions over licensing applications (except in the situation where an appeal is lodged by an applicant), but legal terminology is still commonly used, and barristers still attend Licensing Sub-Committees to represent their clients. Working within a legal framework was a different role for Public Health professionals and one that impacted on the overall professional identity of Public Health. To actively participate in licensing decisions, it could be suggested that there would be a requirement to obtain an understanding of the legal framework surrounding licensing and there are signs that this is occurring. For example, on the PHE website there is now a guide for Public Health teams titled as "Alcohol licensing: using case law"⁵¹ which outlines legal cases that Public Health professionals can use when contributing to licensing hearings⁵². Licensing Sub-Committees are not a legal court of law but while the remnants of legality remain, it is important that Public Health professionals increase their understanding of how to operate within this system.

Turning to a historical view of the professional identity of Public Health department, there is a long tradition of Directors and Consultants in Public Health to be aligned with medicine. In fact, it is a reasonably recent decision to allow non-medical professionals to become employed within senior positions within Public Health. During this research it was suggested that professionals with a non-medical background in Public Health would adopt a wider view

⁵¹ <https://www.gov.uk/government/publications/alcohol-licensing-using-case-law/alcohol-licensing-using-case-law>

of health beyond a medical focus on illness and disease. These individuals were suggested to have a better understanding of the social determinants of health model which includes alcohol. During one interview, the respondent referred to Public Health as scientists and epidemiologists (PH10). This identification of Public Health as scientists would separate Public Health from the other Responsible Authorities who were not scientists.

Within this research, a small number of respondents described altering their approach to licensing decisions away from reliance on data towards working across boundaries as boundary spanners (Williams, 2011). The concept of boundary spanners can be argued as a potential solution to professionals only working within their own frameworks and silos. Williams (2011) provided a definition of boundary spanners as “people and organisations working together to manage and tackle common issues” (Williams, 2011, p27). Within the context of health and social care Williams (2011) proposed that boundary spanners have four main roles and competencies, which were labelled as “Reticulist (networking), entrepreneur (brokering), interpreter (building interpersonal relationships) and organiser (planning and co-ordinating)” (Williams, 2011, p28). Within the field of licensing, where multiple professional identities collaborate, it could be suggested that the ability to work across boundaries and become a boundary spanner would be a good approach to adopt in any attempt to foster increased involvement of Public Health in licensing decisions.

Within this study respondents referred to different Responsible Authority groups continuing to exhibit silo working. One example was provided by a national organisation whose representative explained that at times there were push backs from the police if Public Health attempted to present data on crime and disorder during representations at the Licensing Sub-Committee (N1). In this situation where professionals only worked within their own area and attempted to prevent new professionals from becoming involved, partnership working would suffer. In a scenario where people are only prepared to work within their own boundaries, it is difficult to imagine how and when each group would meet to discuss issues. In addition to silo working there was also the issue of professionals protecting their boundaries (Gieryn, 1999). Public Health professionals, who were already working within a contested space, may attempt to use boundaries as a means of preventing receiving additional responsibilities, and as a way of protecting their existing roles and status as scientists (Gieryn, 1999).

It was not only professional identity that impacted on behaviour as the employing organisation also influences professional identity. The geographical move of Public Health from the NHS to local government had an impact on the professional identity of Public Health professionals. Whilst Public Health were part of the NHS, the dominant identity framework was one of medicine and clinical work but the geographical change to a local authority environment constituted a change to this framework. As Phillips and Green (2015) commented “there has been relatively little research on evidence based Public Health in practice and even less on local government as a site of health policy-making”. This is an area that could be argued as requiring further research to gain knowledge on local authorities as a site for policy making.

Within this research respondents suggested that the move to local government allowed Public Health to gain access to departments that would assist them to work on the wider determinants of health and work around alcohol licensing was classed as part of this new role. But several concerns were mentioned within this research about the move, with some respondents saying they wished that Public Health had remained part of the NHS. Both the NHS and local authorities have faced budget cuts and although Public Health transferred with a ring-fenced budget, Public Health departments have still encountered budget reductions to the Public Health grant.

Within this research one respondent mentioned a crisis of identity for Public Health that was initiated by the move into local government, but within the available literature, difficulties around defining the identity of Public Health were mentioned dating back to the 1980s. The Institute of Medicine (1988, cited in Hunter, 2003, p24) wrote about “a growing sense that Public Health as a profession, as a governmental activity and as a commitment to society is neither clearly defined, adequately supported nor fully understood”. If Public Health was not clearly defined, funded or understood fully, this could have been a precursor to a growing sense that Public Health was in crisis, with the move of Public Health from the NHS to local authorities in the United Kingdom, acting as a pivotal point. From the perspective of the other Responsible Authority groups, Public Health were new to both the political environment of local government and to the quasi legal system of licensing. Initially, from personal experience there were misunderstandings over the remit of Public Health after the transfer to local government. Within this research, it was mentioned that in one borough the

licensing authority was not sure what Public Health were able to do within licensing. Phillips and Green (2015, p493) described local government as being a “creature of stature that exists as a complex web of legislation created through individual acts of national parliament”. This is very different to traditional Public Health working arrangements within the NHS. It is clear from this research that the move of Public Health to local government has had an impact on the professional identity of Public Health. It may take time for this impact to become evident.

Within the next Chapter of this thesis, the conclusions that can be drawn from this research are outlined and discussed, including a discussion over the fundamental question of should Public Health departments work within licensing decisions as a Responsible Authority. Within this research, it has been demonstrated that within the current arrangements there is confusion over the role that Public Health can play and barriers in relation to Public Health working in partnership with other Responsible Authorities. There are also signs of positive changes however, in relation to some respondents suggesting that their role within licensing is legitimate and that with alterations in relation to how information is presented to the Licensing Sub-Committee, they feel that progress is being obtained. The potential limitations of this study are briefly re-visited within the next Chapter along with suggestions of areas for potential further research.

7. Conclusions

This research provides invaluable insights on the experiences of primarily Public Health professionals, who work at local levels in London on alcohol licensing decisions. It comprised of interviews with relevant stakeholders, observation of meetings and analysis of documentation. Within this final Chapter, five conclusions, emerging clearly from the study are outlined and this is followed by implications for practice and suggestions for future research. Finally, some reflections on the role of Public Health within licensing are provided.

7.1 The wider political and policy context impacts on Public Health involvement in licensing

The first conclusion which can be drawn from this research is **the importance of a supportive and facilitating wider political and policy context, to ensure the involvement of Public Health within licensing**. This conclusion is important at both national and regional (London) levels. The United Kingdom is currently experiencing uncertainty in politics, coupled with requests for devolved powers over decision making to local areas and reductions in resources. For Public Health professionals, now located within the political system of local government, this policy and political context is complicated by a wide range of competing priorities which all require attention.

In relation to alcohol strategy and policy, the calls for a new national strategy on alcohol, which have grown stronger since the publication of a national drugs strategy in 2017, appear to have been rewarded with the recent announcement that a new national alcohol strategy will be published shortly. Whilst the contents and publication date of this new document remain unclear, it will be interesting to observe if licensing and especially Public Health involvement in licensing, achieves any great level of prominence within the promised new national alcohol strategy. Without a supportive and facilitating approach by national government towards increasing Public Health involvement in licensing decisions, it is difficult to imagine how the current situation of variable engagement levels, which was a finding within this study, will alter.

Turning to the London region, which was the main geographical area of focus of this research, a new London plan is currently under consultation. Within this document, emphasis

is placed on stating that any changes to licensing processes in relation to controlling the availability of alcohol would require balancing with the promotion of London as an always open, a 24-hour city (GLA, 2017). The marketing of London as an always open city does not, however, suggest the control of alcohol availability through licensing measures is a priority. It is however, indicative of the dilemma observed in some boroughs over balancing competing priorities.

7.2 There is a need to bridge the national policy implementation gap

A second conclusion drawn related to **an implementation gap between the ideal of licensing policy, as formulated at a national level and the experiences of Public Health practitioners at a local implementation level**. The addition of Public Health as a Responsible Authority was formulated by legislation, and within documents reviewed as part of this thesis, the ideal role presented was one where Public Health departments were equal Responsible Authorities, fully engaged and participating in licensing decisions within each borough. However, the views presented by the participants in this study, in some London boroughs highlighted considerable challenges regarding engagement and involvement in licensing decisions.

Within this research, evidence of an implementation gap between national licensing policy and implementation at local levels emerged. The existence of an implementation gap is similar to research findings on licensing in Scotland. North of the border, where there is a specific Public Health licensing objective (titled as ‘protecting and improving Public Health’) it was reported that “implementation remains an area of continued challenge with difficulties in interpreting and applying the objective in practice” (AFS, 2017, p12).

This report by Alcohol Focus Scotland was based on regional licensing seminars and the authors stated that “a significant number do not believe it possible or desirable for the licensing system to operate in a way which optimises Public Health” (AFS, 2017, p10). As Scotland continues to experience issues around the implementation gap, even with an established Public Health licensing objective in place, it is not a surprise that in England, professionals also experience issues with implementation of the national policy ideal at local levels. It is interesting to note that in this report, there was a recommendation for the development of a national licensing policy to provide a driver for the licensing system (AFS, 2017). It could be proposed that the development of a similar document in England could

assist to dispel the implementation gap between policy and practice, plus increase emphasis on licensing policy.

Within this research, it was found that although a consultation had taken place regarding the legislation which heralded the addition of health bodies as a Responsible Authority group, no analysis of the stakeholders involved was undertaken prior to implementation. This added to the implementation gap as the policy was introduced without adequate measurement of the levels of support/opposition and power for the proposal. There is scarce evaluation of overall licensing policy in England in addition, with no built-in evaluation system prior to implementation of the addition of health bodies as a Responsible Authority.

Public Health England complete an annual licensing survey, but whilst this survey aims to gauge the participation levels of Public Health teams within licensing, it does not evaluate the impact of Public Health as a Responsible Authority on population health outcomes. Public Health are Responsible Authorities and there are no indications at present to suggest that this situation will alter, but the lack of clear evaluation of Public Health involvement in licensing decisions, could lead to increases in the gap between policy and practice. Public Health practitioners are relatively unaware of the impact of their involvement in licensing and, do not know if they have achieved the policy ideal.

There are many other factors which have an influence on implementation and serve to create and sustain the implementation gap. These are discussed in the following sections and include Public Health professionals lack of a clear understanding of their roles, the problems they experience in trying to integrate into an established partnership, and the challenges posed by their new role to their sense of professional identity and their professional practice.

7.3 Greater clarity is required regarding the role of Public Health in licensing

A third conclusion from this research was **the need for greater clarity in relation to the role of Public Health departments within licensing**. The definition of the role of Public Health within licensing decisions is not clear and while Public Health professionals appear to understand the requirements of their role, they continue to face issues with operationalising this in some London areas. For example, at a recent licensing event by London School of Hygiene and Tropical Medicine (LSHTM) for the Public Health and Alcohol Licensing (PHAL) study,

attended by this researcher, some attendees voiced concerns over how to achieve the policy ideal in practice. Research by Hallsworth et al (2011), completed on civil servants in London, also pointed to a gap between professionals knowing what they should do but experiencing difficulties turning this into reality. If greater clarity for Public Health professionals over their role within licensing was provided, this could assist Public Health professionals to develop confidence over the development of a legitimate role within licensing decisions.

Confusion surrounding the exact role that Public Health could play within licensing decisions was not confined to Public Health professionals, as other Responsible Authorities within this study, also expressed uncertainty regarding Public Health's role. The other Responsible Authorities argued that the role of Public Health within licensing was limited by the lack of a specific health-based licensing objective and the argument that representations against licence applications required premises specific data. Within this research, a health-based licensing objective was not universally requested by participants and within licensing legislation and there is no requirement for data to be premises specific within the legislation (Foster, 2016). The debate over the necessity for a fifth health-based licensing objective in England continues.

In some London areas, Public Health appeared to have accepted that their role was limited, and this was observed through the adoption by Public Health of a supportive role within licensing decisions. This supportive role was operationalised by the submission of representations against applications only in conjunction with other Responsible Authorities, instead of stand-alone representations. In relation to role confusion, the adoption of a supportive role within licensing could be viewed as an example of a misunderstanding of the role of Public Health within licensing. Public Health as a Responsible Authority have the right to have their views taken into consideration on an equal level as other Responsible Authority groups. Once again, if greater clarity was provided to Public Health professionals over their exact role within licensing decisions, it could be suggested that this will not only improve engagement rates within licensing decisions but could add to the confidence of Public Health professionals over the legitimacy of the role.

7.4 Expectations regarding the inclusion of Public Health in established partnerships around licensing requires review

A fourth conclusion is that **there are issues that arise from the expectation that Public Health as a Responsible Authority will function within the existing partnership around licensing.** Public Health departments were added to the list of Responsible Authorities and were then tasked with engaging within an existing licensing partnership that already had an established history of joint working. Within this study it was found that certain Responsible Authority groups, namely the licensing authority, the police and environmental health played a more dominant role in relation to partnership working within licensing, primarily due to historical closer working relationships between these groups. The involvement of Public Health as a Responsible Authority within licensing is still relatively new, as time progresses Public Health may develop a shared history within the existing Responsible Authority licensing partnership, but this will take time to develop and become established.

The addition of Public Health to an existing partnership creates identity issues, with each Responsible Authority group reacting in a slightly different way to their new partners. The historical licensing partnership is impacted by the addition of Public Health as a Responsible Authority, but also the professional identity of the Public Health professionals is affected. A further issue relating to partnerships concerns the contested space around licensing, where different Responsible Authority groups must compete to ensure that their priorities gain prominence.

For Public Health departments, in addition to the contested space around licensing, there is another contested space within Public Health work itself. Public Health professionals have several competing work agendas and priorities to address, with licensing work constituting only a small part of their overall role. The competition within contested spaces could mean that Public Health do not have resources to dedicate to engaging within an already existing, external partnership. When Public Health were added to the list of Responsible Authorities (along with the licensing authority), no consideration appeared to have been given either to the impact that this would have on the existing Responsible Authority groups involved in licensing, or on the Public Health professional's ability to smoothly integrate within an established partnership.

During the literature review for this study, generic factors which facilitated partnership working were documented. These factors were trust, equal levels of power over decision making, the sharing of goals etc (Wildridge et al, 2004, Thom et al, 2011). Specifically, in relation to licensing partnership work, in addition to facilitators drawn from the literature, additional factors were found from this study and these were:

- **Flexibility** – Move away from a reliance on purely statistical Public Health data to consideration of other forms of evidence and working practices.
- **Local context** – Greater understanding of the local context facilitated involvement in licensing. For example, boroughs with a larger Night Time Economy (NTE) and more visible alcohol related issues such as crime and disorder.
- **Boundary spanners** – working across different professional boundaries within licensing partnerships assisted with partnership working as silo working practices were reduced and it appeared to build trust between different Responsible Authority groups.
- **Dedicated resources** – Not only budgetary resources, also people and time to enable full participation in licensing work.

The importance of Public Health being flexible and adapting their ways of working within licensing emerged clearly from the data in this research. Part of this flexibility included becoming boundary spanners and working across a range of professional boundaries to facilitate increased involvement within licensing. Having dedicated resources in relation to time and staff emerged as a facilitator but this is not an uncommon issue, especially in the current context of reducing budgets and staff resources. In summary, if the facilitators above were implemented, it is proposed that improvements could be observed in relation to Public Health integration within an established partnership and in overall involvement levels within licensing decisions.

7.5 Perceptions of professional identity pose difficulties for engaging Public Health in licensing

The final conclusion obtained from this study is that **there are difficulties arising from perceptions of professional identity and how the shifts into local authorities and into a licensing role impact on professional identity**. Public Health departments transferred from a 'health' model of working within the National Health Service, into the political environment

of local government. For Public Health professionals, whose professional identity historically aligned with medicine, this represented a change in professional identity. The impacts of this move on identity are still developing. Licensing processes operate within a quasi-legal framework, which is new to Public Health practitioners. This could lead Public Health professionals who were tasked with participating in licensing decisions with feelings of inadequacy over their role and this is exacerbated by challenges from other professionals regarding the different kinds of knowledge and expertise required for participation as a Responsible Authority.

7.6 Recommendations for future research

The role of Public Health within licensing decisions is an evolving role, which therefore provides several opportunities for future research on this topic. As this process continues it will be important for research to continue monitoring of the level of engagement achieved by Public Health within licensing. Buse et al (2012) discuss stakeholder analysis in detail within their work. To date no stakeholder analysis has been completed regarding the addition of Public Health as a Responsible Authority within licensing decisions. Although the stakeholder analysis would have to be completed retrospectively, as Public Health are already working within licensing, the benefits of completion of this analysis could be useful in relation to identification of professionals who could assist with policy implementation. If key stakeholders with high levels of power and support for the policy were identified they could act as champions for the policy of Public Health involvement in alcohol licensing. The converse would also apply, where by actors who did not support the policy could be identified and work commenced to alter this situation.

As previously mentioned within this Chapter, the actual impact of Public Health involvement within licensing on population level alcohol related health harms is unclear. Research to ascertain the impact achieved by Public Health being involved in licensing would be useful in relation to the assumption that it is a policy which delivers benefits to population health.

During the seven months of observations of Licensing Sub-Committee meetings completed for this study, there was only one occasion when a representation from Public Health was heard by the committee. It would have been interesting to observe further interactions between the Licensing Sub-Committee members and Public Health but due to time

limitations this was not possible within this study. This is an area where future research could focus, and studies could also examine partnership working in greater detail, perhaps with a specific focus on areas where Public Health departments are struggling to operationalise their role within licensing.

Finally, during meeting observations, members of the public attended to present evidence and on one occasion to call for a review of a licence. From the field notes produced from this observation, it was obvious that members of the public were unfamiliar with licensing procedures. One potential area for future research could be in relation to examining the potential of increased involvement from members of the public within licensing decisions and potentially linking this with Public Health departments.

7.7 Reflections on the role of Public Health within licensing

At the beginning of this thesis, this study was designed by a researcher with a background in Public Health, who was convinced that the role of Public Health as a Responsible Authority was important, worthwhile and felt that the outcome of this PhD would lead to the production of a set of guidelines to improve current practice.

As the PhD progressed however, the researcher began to question the overall effectiveness of having Public Health departments engaged as a Responsible Authority within licensing decisions. Concerns emerged over the ability of Public Health involvement in licensing to achieve a measurable reduction in population level alcohol related health harms. At the end of this thesis, the policy of Public Health involvement in licensing decisions remains to have variable involvement levels across London, with some boroughs reporting successful engagement and others continuing to face difficulties around operationalising this policy. As a Public Health professional, questioning the appropriateness of the policy of Public Health working within licensing decisions was uncomfortable. As part of this research also examined the professional identities of different Responsible Authority groups in addition, this led the researcher to reflect upon their own professional identity.

It could be suggested that it is unlikely that Public Health, having been added as a Responsible Authority, will suddenly cease to hold this position and therefore any further discussion relating to the appropriateness of Public Health as a Responsible Authority would

be purely speculation at this point. There are ongoing research studies such as the London School of Hygiene and Tropical Medicine's, Public Health and Alcohol Licensing (PHAL) study (Reynolds et al, 2018) and the United Kingdom centre for tobacco and alcohol studies, ExLEns (Exploring the Impact of Alcohol Licensing in England and Scotland) project, which aim to further explore the involvement of Public Health in licensing and potentially provide recommendations for improving practice.

There were limitations within this study, relating to the researcher's abilities, potential bias introduced by the researcher's background, the accuracy of the data provided by interviewees and the focus of this study being on the London region. Despite these limitations mentioned earlier (section 4.9), the data obtained from this study added new knowledge and understanding around licensing decisions. The resulting data emerging from interviews, analysis of documentation and meeting observations provided a few potential facilitators for improving the involvement of Public Health within licensing decisions and outlined the barriers that remain in place in some areas. Whilst some London boroughs continue to experience difficulties in relation operationalising the role of Public Health within licensing, Public Health professionals across London continue to be industrious around potential roles within licensing and develop alternative ways of working in attempts to achieve the policy ideal. Without this ongoing work by Public Health professionals at local and national levels, participation of Public Health within licensing decisions will continue with variable levels of engagement.

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9. Appendices

9.1 Appendix 1 Study Information Sheet

Information Sheet for Research Participants
Study Title Public Health and alcohol licensing in London: Partnership working and professional ideologies
You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to consider whether or not you wish to take part.
What is the purpose of the study? The Purpose of the study is to look at the involvement of Public Health departments across London in alcohol licensing decisions. I am conducting the study for my PhD and it is an area that I am interested in studying due to previous work experience in Public Health and addictions. I hope that the study will uncover ways in which Public Health departments across London can become more engaged in alcohol licensing. The study will run for approximately one year.
Why have I been chosen? You were chosen due to your knowledge and/or experience around alcohol licensing. The Director of Public Health within your borough was asked to suggest people whom I should speak to for the study.
Do I have to take part? It is up to you to decide whether or not to take part. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time and without giving a reason.

What will happen to me if I take part?

If you are happy to participate, I will contact you to discuss a suitable time for an interview. This can be arranged at your convenience. Before we start I will answer any questions you have, and you will have signed an electronic consent form if you are happy to go ahead. The interview will last no longer than one hour. As it states on the consent form, the interview will be tape recorded. It is recorded as otherwise I will not be able to accurately record everything that is discussed, and I may miss an important point that you make.

What are the possible disadvantages and risks of taking part?

There is no known risk in taking part in this research.

What are the possible benefits of taking part?

I hope that participating in the study will help you. However, this cannot be guaranteed. The information I gain from this study may improve the involvement of Public Health in alcohol licensing across London.

Will my taking part in this study be kept confidential?

All information that is collected about you during the course of the research will be kept strictly confidential. Any information about you which is used will have your name and address removed so that you cannot be recognised from it. All recorded tapes are stored safely and destroyed after they have been analysed and reported as per the Data Protection Legislation in the UK. If you have any documents which may be helpful to the research and are happy to share them, these will be included in the analysis with your permission

What will happen to the results of the research study?

The results are likely to be published upon successful completion of this research for my PhD. At the end of the study, the results can be made available to you should you wish. Please contact me for a copy.

Contact for further information:

Linda Somerville and/or Betsy Thom

Middlesex University, The Boroughs, London, NW 4 4BT

Telephone: 0208 411 5281

Email: l.somerville@mdx.ac.uk ; b.thom@mdx.ac.uk

Your help is greatly appreciated. Thank you for taking part in the study.

You will be given a copy of this sheet and the signed consent form for you to keep.

9.2 Appendix 2 Consent Form

Participant Identification Number:

CONSENT FORM

Title of Project: Public Health and alcohol licensing in London: Political reforms, partnership working and localism.

Name of Researcher:

1. I confirm that I have read and understand the information sheet dated for the above study and have had the opportunity to ask questions.
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.
3. I agree that this form that bears my name and signature may be seen by a designated auditor.
4. I am assured that the confidentiality of my data will be upheld through the removal of any personal identifiers.
5. I understand that my interview may be taped and subsequently transcribed.
6. I agree to take part in the above study.

Name of Participant

Date

Signature

Researcher

Date

Signature

1 copy for participant; 1 copy for researcher

9.3 Appendix 3 Ethics Committee Approval letter



School of Health & Education
The Burroughs
Hendon
London NW4 4BT

Main Switchboard: 020 8411 5000

24/04/15

HEESC APPLICATION NUMBER: MH09 Linda Somerville and Professor Thom

Dear Linda and Professor Thom

Re your application titled: "Public Health and alcohol licensing in London: political reforms, localism and partnership working".

Thank you for submitting your revised application. I can confirm that your application has been given approval from the date of this letter. Please ensure that you contact the ethics committee via Leeann Bradley l.f.bradley@mdx.ac.uk if there are any changes to the study to consider possible implications for ethics approval. The committee would be pleased to receive a copy of the summary of your research study when completed.

Please quote the application number in any correspondence.

Good luck with your research.

Yours sincerely

A handwritten signature in black ink that reads "Gordon".

Dr Gordon Weller
Chair of Health & Education Ethics Committee

9.4 Appendix 4 Pilot Interview Schedule

Pilot interview schedule
1. Name:
2. Please could you confirm the organisation you work for and your job title.
<p>3. The general context of Public Health:</p> <ul style="list-style-type: none">• (First of all, I would like your opinion on Public Health in general): What is your view on the shift of Public Health from the NHS to local authorities? Probes:• What did respondent think of it originally, has respondent changed his mind in the light of subsequent experience (allow respondent to talk and expand if he seems inclined to)• What changes did the move to local authorities entail – perceptions of the general situation and then – Did this apply to this borough (if appropriate)• From your point of view, in this borough, how successful has the move to local authorities been? Probe: problems and what has gone well / why• In your relatively limited experience, how do you think having Public Health set within the local authority is working?• How do you think your borough is managing?
<p>4. Turning to alcohol licensing in particular:</p> <ul style="list-style-type: none">• What do you see as the main role for Public Health in alcohol licensing? Probe: reasons/ explanations for anything offered• The notion of ‘engagement’ is often used when discussing Public Health involvement in alcohol licensing: Can you say what this term ‘engagement’ means to you? Probes: what would constitute full/good engagement; what prevents this happening; what facilitates engagement.• In your borough, have you seen any changes in the level of engagement since Public Health became Responsible Authority? Probe: what, how it came about, issues arising etc. (Some of this is likely to have come out in prior discussion – you need to adapt).• To what extent do you think that central government should be directing Public Health involvement in Licensing, rather than leaving it to local authorities?

5. Partnership working:

- From your experience, what issues (if any) arise in trying to work in partnership with other Responsible authorities around licensing? (You might want to ask if this is specific to alcohol or if similar issues arise in relation to partnership around other health/lifestyle issues – i.e., probe if the issues are specific to alcohol or more general regarding Public Health collaborating with other Authorities/professionals)
- (depending on the answers above) In this borough, what is the experience of working with another Responsible Authority's? Probe: how Public Health regards the other Responsible Authority's and perceptions of how other Responsible Authority's regard Public Health) In this borough, is there a system to facilitate joint working (e.g. Forum)? Probe: perceptions of whether it works well or not/ reasons; level of Public Health engagement/reasons etc.
- What would you say are the desired outcomes of Public Health working in partnership with the other Responsible Authority's around alcohol licensing? Probes: are all partners working to the same outcome? Was a discussion held with all Responsible Authority's to decide on the outcomes

9.5 Appendix 5 Sample Interview Schedules for the Main Study

Sample Interview Schedule -Public Health (Strategic)
<p>1) Could you tell me what education and training you have undertaken to become a DPH?</p> <ul style="list-style-type: none"> • Probes: was the education and training essential for your role or did you take on additional education/training for other reasons?
<p>2) What is your view on the shift of Public Health from the NHS to local authorities?</p> <ul style="list-style-type: none"> • Probes: what did respondent think of it originally; has respondent changed his mind in the light of subsequent experience (allow respondent to talk and expand if he seems inclined to) • In your relatively limited experience, how do you think having Public Health set within the local authority is working? What is going well/What is going not so well?
<p>3) What do you see as the main roles for Public Health in alcohol licensing?</p> <ul style="list-style-type: none"> • Probes: Do you see the role as limited and if so in what ways is it limited? Who applies these limits? Public Health or other responsible authorities? What do you think would need to change to remove the limitations on the role?
<p>4) The current guidance suggests that Public Health data should be viewed with an equal amount of weight as other data, what do you think of this⁵³?</p>
<p>5) Do you think the addition of health as a fifth licensing objective would change the roles of Public Health in alcohol licensing decisions in any way?</p>
<p>6) How would you describe the Public Health approach to alcohol licensing decisions within your borough/s?</p> <ul style="list-style-type: none"> • Is alcohol licensing part of the JSNA and/or discussed at the Health and wellbeing board? • Has the Public Health approach altered since Public Health became a responsible authority?

⁵³ Initially this question was 'the current guidance says that PH data shouldn't be used as the primary consideration for a licensing decision'. This was based on research by Martineau et al (2013) and Amended Guidance Issued under Section 182 of the Licensing Act 2003 (2012). The question was changed after amended Section 182 guidance was published. On reflection, the interviewee spoke about PH data and not about the weight it carried in decisions.

7) Which term do you think most accurately describes the Public Health approach towards alcohol licensing within your borough? Evidence based, legislative, regulatory, statutory for example?

- Probes – Do you think that the reliance on one approach influences the work completed around alcohol licensing decisions?
- Would some different approach assist/place barriers in the way of working around alcohol licensing decisions?

8) Is there a clearly defined strategy in place outlining Public Health involvement in alcohol Licensing decisions within your borough/s?

- Probes: Would you say goals are shared, agreed jointly with all Responsible Authority's and enough resources are available to achieve them?

9) Would you say there is a champion within the borough for this agenda?

- Probes: Does this champion keep alcohol licensing high on the priority list? How does this champion demonstrate in practice that they are a champion for this agenda?

10) Would you say that all responsible authorities are equally involved or engaged in alcohol licensing decisions?

- Probes: If some groups are more influential why do think this is the case or if equal, how is this demonstrated in practice
- Is there anything that could change to ensure that all Responsible Authority's achieve equal involvement?

11) Please rate the following professional groups in relation to their influence within alcohol licensing decisions (1= Very high, 2= High, 3= average, 4 = low, 5 = very low)

- Probes: Why do you rate ... as top? Why is ...rated at the bottom?

• Local Councillors	• Public Health
• Police	• Fire Brigade
• Children's Services	• Environmental Health
• Health and Safety	• Planning
• Trading standards	• Licensing Authority

12) What words would you use to describe your working relationship with the other strategic professionals such as the Director of Licensing, the Licensing Sub-committee councillors, the police etc.?

- Probes: Would you describe the relationship as working as partners, collaborative or something else? Is there a different relationship with each Responsible Authority group?
- From your experience, what issues (if any) arise in trying to work in partnership with other Responsible Authority's around licensing?

13) From the list of professional groups below please rate each one in relation to its involvement in partnership working around alcohol licensing decisions (1= very Involved 2= involved, 3= fairly involved, 4= poor involvement, 5= very poor involvement)

• Local Councillors	• Public Health
• Police	• Fire Brigade
• Children's Services	• Environmental Health
• Health and Safety	• Planning
• Trading Standards	• Licensing Authority

- Probes: Why do you rate ... as top? Why is ...rated at the bottom?

14) Has it been empowering to develop a local strategy for licensing or do you feel that alcohol strategy should be developed centrally and distributed to local boroughs?

15) Where did you develop your strategy from? Was it national documents, regional work, PHE, SSLP, GLA work for example?

16) Have you heard of and/or had contact with an organisation named Safe Sociable London Partnership (SSLP)?

- Probes: Could you explain in your own words what you think the role/roles of SSLP is across London? What has your contact with SSLP focused on? For e.g. training, support around implementing Public Health involvement in the licensing process or something else?

17) Have you had any contact with Public Health England around Public Health involvement in alcohol licensing decisions?

- Probes: In your own words, what would you say is the role of PHE in the licensing process?

18) Would anything need to change to further develop your involvement in alcohol licensing decisions?

Sample Interview Schedule - Public Health (Front line)

- 1) Could you tell me what education and training you have undertaken for your current post?
 - Probes: Was all the education and training essential for your role or did you take on additional education/training for other reasons?
- 2) What is your view on the shift of Public Health from the NHS to local authorities?
 - Probes: what did respondent think of it originally; has respondent changed his mind in the light of subsequent experience (allow respondent to talk and expand if he seems inclined to)
 - what changes did the move to local authorities entail – perceptions of the general situation and then – Did this apply to this borough (if appropriate)
 - From your point of view, in this borough, how successful has the move to local authorities been? Probe: problems and what has gone well / why
 - In your relatively limited experience, how do you think having Public Health set within local authorities is working? What is going well/What is going not so well
- 3) What do you see as the main roles for Public Health in alcohol licensing?
 - Probes: Do you see the role as limited and if so in what ways is it limited? Who applies these limits? Public Health or other responsible authorities? What do you think would need to change to remove the limitations on the role?
- 4) ⁵⁴The current guidance suggests that Public Health data should be viewed with an equal amount of weight as other data, what do you think of this?
- 5) Do you think the addition of health as a fifth licensing objective would change the roles of Public Health in alcohol licensing decisions in any way?
- 6) How would you describe the Public Health approach to alcohol licensing decisions within your borough/s?
- 7) Has the Public Health approach altered since Public Health became a responsible authority?
- 8) Do you feel Public Health's involvement in alcohol licensing decisions is a priority within your borough?

⁵⁴ Initially this question was 'the current guidance says that PH data shouldn't be used as the primary consideration for a licensing decision'. This was based on research by Martineau et al (2013) and Amended Guidance Issued under Section 182 of the Licensing Act 2003 (2012). The question was changed after amended Section 182 guidance was published. On reflection, the interviewee spoke about PH data and not about the weight it carried in decisions.

9) Which term do you think most accurately describes the Public Health approach towards alcohol licensing within your borough; evidence based, legislative, regulatory, statutory?

- Probes – Do you think that the reliance on one approach influences the work completed around alcohol licensing decisions?
- Would some different approach assist/place barriers in the way of working around alcohol licensing decisions?

10) Is there a clearly defined strategy in place outlining Public Health involvement in alcohol licensing decisions within your borough/s?

- Probes: Would you say goals are shared, agreed jointly with all Responsible Authority's and enough resources are available to achieve them?

11) Would you say there is a champion within the borough for this agenda?

- Probes: How does this champion keep alcohol licensing high on the priority list? How does this champion demonstrate in practice that they are a champion for this agenda?

12) Would you say that all responsible authorities are equally involved or engaged in alcohol licensing decisions? Probes: If some groups are more influential why do think this is the case?

13) Is there anything that could change to ensure that all Responsible Authority's achieve equal involvement?

14) If equal, how is this demonstrated in practice?

15) Please rate the following professional groups in relation to their influence within alcohol licensing decisions (1= Very high, 2= High, 3= average, 4 = low, 5 = very low)

• Local Councillors	• Public Health
• Police	• Fire Brigade
• Children's Services	• Environmental Health
• Health and Safety	• Planning
• Trading standards	• Licensing Authority

- Probes: Why do you rate ... as top? Why is ...rated at the bottom?

16) What words would you use to describe your working relationships with other responsible authorities/professionals such as Licensing officers, the Licensing Subcommittee councillors, police etc.?

- Probes: Would you describe the relationship as working as partners, collaborative or something else? Is there a different relationship with each Responsible Authority group?

17) From your experience, what issues (if any) arise in trying to work in partnership with other Responsible Authority's around licensing?

18) From the list of professional groups below please rate each group in relation to its involvement in partnership working around alcohol licensing decisions (1= very Involved 2= involved, 3= fairly involved, 4= poor involvement, 5= very poor involvement)

• Local Councillors	• Public Health
• Police	• Fire Brigade
• Children's Services	• Environmental Health
• Health and Safety	• Planning
• Trading standards	• Licensing Authority

- Probes: Why do you rate ... as top? Why is ...rated at the bottom?

19) Have you heard of and/or had contact with an organisation named Safe Sociable London Partnership (SSLP)?

- Probes: Could you explain in your own words what you think the role/roles of SSLP is across London? What has your contact with SSLP focused on? For e.g. training, support around implementing Public Health involvement in the licensing process or something else?

20) Have you had any contact with Public Health England around Public Health involvement in alcohol licensing decisions?

- Probes: In your own words, what would you say is the role of PHE in the licensing process?

Sample Interview Questions – Licensing (Strategic)

- 1) Could you tell me what professional education and training you have undertaken to become a Licensing Manager?
- 2) What is your view on the addition of Public Health as a responsible authority and the move to the local authorities?
 - Probes: what did respondent think of it originally; has respondent changed his mind in the light of subsequent experience (allow respondent to talk and expand if he seems inclined to)
 - What changes has the move of Public Health to local councillors caused for licensing? perceptions of the general situation and then – Did this apply to this borough (if appropriate)
 - From your point of view, in this borough, how successful has the additional of Public Health to local authorities been? Probe: problems and what has gone well / why
 - How do you think your borough is managing? What is going well/what is going not so well
- 3) What do you see as the main roles for Public Health colleagues in alcohol licensing?
 - Probes: Do you see the role as limited and if so in what ways is it limited? Who applies these limits? Public Health or other responsible authorities? What do you think would need to change to remove the limitations on the role?
- 4) ⁵⁵The current guidance suggests that Public Health data should be viewed with an equal amount of weight as other data, what do you think of this?
- 5) that Public Health is equal to other responsible authorities and that Public Health data should carry similar weight to other data sources, what do you think of this?
- 6) Do you think the addition of health as a fifth licensing objective would change the roles of Public Health in alcohol licensing decisions in any way?
- 7) How would you describe the strategic approach that Public Health has adopted around alcohol licensing decisions within your borough/s?
 - Do you feel that this approach is correct, or could it be improved?
 - Would you like to see an increase in Public Health involvement at a strategic level or do you think the current level is good?

⁵⁵ Initially this question was 'the current guidance says that PH data shouldn't be used as the primary consideration for a licensing decision'. This was based on research by Martineau et al (2013) and Amended Guidance Issued under Section 182 of the Licensing Act 2003 (2012). The question was changed after amended Section 182 guidance was published. On reflection, the interviewee spoke about PH data and not about the weight it carried in decisions.

8) Which term do you think most accurately describes the Public Health approach towards alcohol licensing within your borough; evidence based, legislative, regulatory, statutory?

- Probes – Do you think that the reliance on one approach influences the work completed around alcohol licensing decisions?

9) Is there a clearly defined strategy in place outlining Public Health involvement in alcohol licensing decisions within your borough/s?

- Probes: Would you say goals are shared, agreed jointly with all Responsible Authority's and enough resources are available to achieve them?

10) Would you say there is a champion within your borough?

- Probes: Do you think the DPH could do more to increase the priority level of alcohol licensing within your area?

11) Would you say that all responsible authorities are equally involved or engaged in alcohol licensing decisions?

- Probes: If some groups are more influential why do think this is the case?
- Is there anything that could change to ensure that all Responsible Authority's achieve equal involvement?
- If equal, how is this demonstrated in practice?

12) Please rate the following professional groups in relation to their influence within alcohol licensing decisions (1= Very high, 2= High, 3= average, 4 = low, 5 = very low)

• Local Councillors	• Public Health
• Police	• Fire Brigade
• Children's Services	• Environmental Health
• Health and Safety	• Planning
• Trading standards	• Licensing Authority

- Probes: Why do you rate ... as top? Why is ...rated at the bottom?

13) What words would you use to describe your working relationship with the other strategic responsible authorities such as the Director of Public Health, the Licensing Sub-committee councillors, the police etc.?

- Probes: Would you describe the relationship as working as partners, collaborative or something else? Is there a different relationship with each Responsible Authority group?
- How has it been to work across different groups around alcohol licensing decisions?
- Has your experience of working across different groups altered with the addition of Public Health as responsible authorities?
- From your experience, what issues (if any) arise in trying to work in partnership with other Responsible Authority's around licensing?

14) Do you feel that Public Health has a good understanding of the licensing legislation and of their role in the licensing process?

- Probe – how is this demonstrated in practice?

15) When was the last representation received from Public Health? When was the last time that Public Health attended a Licensing Sub-committee meeting?

16) From the list of professional groups below please rate each group in relation to its involvement in partnership working around alcohol licensing decisions (1= very Involved 2= involved, 3= fairly involved, 4= poor involvement, 5= very poor involvement)

• Local Councillors	• Public Health
• Police	• Fire Brigade
• Children's Services	• Environmental Health
• Health and Safety	• Planning
• Trading standards	• Licensing Authority

- Probes: Why do you rate ... as top? Why is ...rated at the bottom?

17) Licensing legislation is published nationally but local policy is developed on a borough basis and written within the SOLP. To what extent do you feel that a template for SOLP's should be written centrally and distributed to local areas?

- Probes – Do you feel that the Public Health department contributed fully to the last review of SOLP?

18) Have you heard of and/or had contact with an organisation named Safe Sociable London Partnership (SSLP)?

- Probes: Could you explain in your own words what you think the role/roles of SSLP is across London? What has your contact with SSLP focused on? For e.g. training, support around implementing Public Health involvement in the licensing process or something else?

19) Have you had any contact with Public Health England around Public Health involvement in alcohol licensing decisions?

- Probes: In your own words, what would you say is the role of PHE in the licensing process?

20) Do you feel that anything needs to change to improve the involvement of Public Health in alcohol licensing at a strategic level locally?

Sample Interview Schedule – Licensing Officer (Frontline)

- 1) Could you tell me what professional education and training you have undertaken for your current post?
- 2) What is your view on the addition of Public Health as a responsible authority and the move to local authorities?
 - Probes: what did respondent think of it originally; has respondent changed his mind in the light of subsequent experience (allow respondent to talk and expand if he seems inclined to)
- 3) From your point of view, in this borough, how successful has the move to local authorities been? Probe: problems and what has gone well / why
- 4) How do you think your borough is managing? What things are going well/Not going so well?
- 5) What do you see as the main roles for Public Health colleagues in alcohol licensing?
 - Probes: Do you see the role as limited and if so in what ways is it limited? Who applies these limits? Public Health or other responsible authorities? What do you think would need to change to remove the limitations on the role?
- 6) ⁵⁶The current guidance suggests that Public Health data should be viewed with an equal amount of weight as other data, what do you think of this?
- 7) Do you think the addition of health as a fifth licensing objective would change the roles of Public Health in alcohol licensing decisions in any way?
- 8) How would you describe the Public Health approach to alcohol licensing decisions within your borough/s?
 - Do you feel that this approach is correct, or could it be improved?
 - Do you feel Public Health involvement in alcohol licensing decisions is a priority within your borough?
 - Would you like to see more involvement from Public Health colleagues in licensing decisions or do you think the current level is about right?

⁵⁶ Initially this question was 'the current guidance says that PH data shouldn't be used as the primary consideration for a licensing decision'. This was based on research by Martineau et al (2013) and Amended Guidance Issued under Section 182 of the Licensing Act 2003 (2012). The question was changed after amended Section 182 guidance was published. On reflection, the interviewee spoke about PH data and not about the weight it carried in decisions.

9) Which term do you think most accurately describes the Public Health approach towards alcohol licensing within your borough; evidence based, legislative, regulatory, statutory?

- Probes – Do you think that the reliance on one approach influences the work completed around alcohol licensing decisions?
- Would a different approach assist/place barrier in the way of working around alcohol licensing decisions?

10) Is there a clearly defined strategy in place outlining Public Health involvement in alcohol licensing decisions within your borough/s?

- Probes: Would you say goals are shared, agreed jointly with all Responsible Authority's and enough resources are available to achieve them?

11) Is there a champion within the borough?

12) Would you say that all responsible authorities are equally involved or engaged in alcohol licensing decisions?

- Probes: If some groups are more influential? Why do think this is the case?
- Is there anything that could change to ensure that all Responsible Authority's achieve equal involvement?
- If equal, how is this demonstrated in practice?

13) Please rate the following professional groups in relation to their influence within alcohol licensing decisions (1= Very high, 2= High, 3= average, 4 = low, 5 = very low)

• Local Councillors	• Public Health
• Police	• Fire Brigade
• Children's Services	• Environmental Health
• Health and Safety	• Planning
• Trading standards	• Licensing Authority

- Probes: Why do you rate ... as top? Why is ...rated at the bottom?

14) What words would you use to describe your working relationships with other professionals such as Public Health colleagues, the Licensing Sub-committee councillors, police etc.?

- Probes: Would you describe the relationship as working as partners, collaborative or something else? Is there a different relationship with each Responsible Authority group?

15) How has it been to work across different groups around alcohol licensing decisions?										
16) From your experience, what issues (if any) arise in trying to work in partnership with other Responsible Authority's around licensing?										
<p>17) From the list of professional groups below please rate each group in relation to its involvement in partnership working around alcohol licensing decisions (1= very Involved 2= involved, 3= fairly involved, 4= poor involvement, 5= very poor involvement)</p> <table border="1"> <tr> <td>• Local Councillors</td> <td>• Public Health</td> </tr> <tr> <td>• Police</td> <td>• Fire Brigade</td> </tr> <tr> <td>• Children's Services</td> <td>• Environmental Health</td> </tr> <tr> <td>• Health and Safety</td> <td>• Planning</td> </tr> <tr> <td>• Trading standards</td> <td>• Licensing Authority</td> </tr> </table> <ul style="list-style-type: none"> • Probes: Why do you rate ... as top? Why is ...rated at the bottom? 	• Local Councillors	• Public Health	• Police	• Fire Brigade	• Children's Services	• Environmental Health	• Health and Safety	• Planning	• Trading standards	• Licensing Authority
• Local Councillors	• Public Health									
• Police	• Fire Brigade									
• Children's Services	• Environmental Health									
• Health and Safety	• Planning									
• Trading standards	• Licensing Authority									
<p>18) Licensing legislation is published nationally but local policy is developed on a borough basis and written within the SoLP. To what extent do you feel that a template for SoLP's should be written centrally and distributed to local areas?</p> <ul style="list-style-type: none"> • Probes – Do you feel that the Public Health department contributed fully to the last review of SoLP? 										
<p>19) Have you heard of and/or had contact with an organisation named Safe Sociable London Partnership (SSLP)?</p> <ul style="list-style-type: none"> • Probes: Could you explain in your own words what you think the role/roles of SSLP is across London? What has your contact with SSLP focused on? For e.g. training, support around implementing Public Health involvement in the licensing process or something else? 										
<p>20) Have you had any contact with Public Health England around Public Health involvement in alcohol licensing decisions?</p> <ul style="list-style-type: none"> • Probes: In your own words, what would you say is the role of PHE in the licensing process? 										
<p>21) Do you feel that anything needs to change to improve the involvement of Public Health in alcohol licensing at a strategic level locally?</p>										

9.6 Appendix 6 Checklist for Analysis of Documentation

Documentation Analysis: Area _____

Document Title:

Dates covering:

Author/s:

<p>1) How does the document look?</p> <ul style="list-style-type: none"> • Professional? • Corporate? • Who issued this document? • Who is the document aimed at? • Description of the document e.g. executive summary, report? 	
<p>2) Any barriers to reading the document?</p> <ul style="list-style-type: none"> • Long? • Jargon used? • Plain English (if aimed at the public)? 	
<p>3) Contents:</p> <ul style="list-style-type: none"> • In what context is Public Health Mentioned? • In what context is alcohol mentioned? • In what context is alcohol licensing mentioned? • In what context is Public Health and alcohol licensing mentioned? • Is there a specified role that Public Health will play in alcohol licensing decisions? • Is there a specification around partnership working around alcohol licensing? • How are the roles of the different responsible authorities defined? • Is there a definition of the roles that the different responsible authorities will play? • Is there a clear definition of the goals of partnership working? • Are there any definitions of the outcomes to be achieved from this work stream? 	
<p>4) When is this document to be reviewed? Who will review it? What evidence has been used to support this document. research, national stats, local stats, experiential learning?</p>	

9.7 Appendix 7 Field Notes form for Observation of Meetings

Meeting Observation Notes:

Date of Meeting:

Time:

Meeting Title:

1) <i>Who is present: Name, Job Titles, Role, apologies</i>	
2) <i>Meeting Location and Spatial issues:</i>	
3) <i>Agenda: What is for discussion Is the agenda adhered to? If not, why is it not? One off meeting or series? Are the agenda's fixed or are they flexible? What position is Public Health/Alcohol Licensing on the agenda?</i>	
4) <i>Who is the Chair? Is it the same chair always or is there a rotating chair? Who leads on this meeting? Does everyone contribute? Who contributes what and how often? Does anyone not participate? What is the approach to issues, e.g. discussion, one person leads etc.</i>	
5) <i>Public involvement? (Licensing committee)</i>	
6) <i>Language barriers/terminology/Legal discussion</i>	
7) <i>Any additional conversations outside of the meeting?</i>	
8) <i>Meeting conclusion: Actions for each participant outlined and agreed? Any unresolved issues? Future plans agreed in a consensus? Were there any arguments? Does everyone agree with the next steps or were different opinions around the actions to be taken? Is it clear who is responsible to complete each action?</i>	
9) <i>Any additional points to note? Body language during the meeting? Tone of voice? Any unaddressed issues?</i>	