Local policies to tackle a national problem: Comparative qualitative case studies of an English local authority alcohol availability intervention.

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Abstract

Cumulative impact policies (CIPs) are widely used in UK local government to help regulate alcohol markets in localities characterised by high density of outlets and high rates of alcohol related harms. CIPs have been advocated as a means of protecting health by controlling or limiting alcohol availability. We use a comparative qualitative case study approach (n=5 English local government authorities, 48 participants) to assess how CIPs vary across different localities, what they are intended to achieve, and the implications for local-level alcohol availability. We found that the case study CIPs varied greatly in terms of aims, health focus and scale of implementation. However, they shared some common functions around influencing the types and managerial practices of alcohol outlets in specific neighbourhoods without reducing outlet density. The assumption that this will lead to alcohol harm-reduction needs to be quantitatively tested.

Keywords: alcohol, neighbourhood environment, public health, case study.

Highlights.

- Cumulative impact policies (CIPs) are a means of regulating alcohol licensing.
- CIPs involve locally tailored criteria for accepting or rejecting licence applications.
- The CIPs we studied define and discourage types of alcohol outlet perceived to be harmful.

- They also define and encourage alcohol outlets perceived to be not harmful.
- The health impacts of modifying outlet type, rather than density, are not known.

Introduction

For many countries, alcohol related harm is a major national health concern (World Health Organisation, 2014) that increases healthcare costs (Scarborough et al., 2011) in addition to costs from crime and disorder and losses of workplace productivity (Anderson et al., 2009). Although frequently regarded as a national problem, interventions to prevent or treat alcohol related harms are often developed and administered at the level of local government (Alcohol Public Policy Group, 2010; Fitzgerald and Angus, 2015; Hech et al., 2014). For example, restriction of alcohol availability is a key area of interest to policy-makers and practitioners, both in the UK and elsewhere, but restrictions can take different forms and their delivery varies by locality (Foster and Charalambides, 2016; Livingston, 2012; Nicholls, 2012). They may, for example, take the form of modifications to economic availability (e.g. raising the price of alcohol); spatial availability (e.g. reducing spatial density of alcohol outlets) and temporal availability (e.g. restricting times of sale).

Currently, the licensing of alcohol outlets represents arguably the most important lever for modifying the spatial and temporal availability of alcohol in the UK: a process that is administered by local licensing authorities (Martineau et al., 2013a; Nicholls, 2015). In England, the focus of this study, licensing authorities are situated in 326 principal local government authorities (LGAs) and have considerable leeway to develop tailored alcohol strategies, drawing on a mixture of compulsory and discretionary powers. This provides a mechanism for local variation in the type of interventions delivered and the 'intensity' of delivery. De Vocht et al (2015) have found that 'intensity' of local licensing policies, which they defined as willingness to administer cumulative impact policies (explained below) and refuse licence applications, was associated with area-level reductions in alcohol-related

hospital admissions. This raises the possibility that variations in local licensing policy can influence area based inequalities in alcohol related harms.

Cumulative Impact Policies

This study focuses on a discretionary intervention that is available to licensing authorities in LGA's in England and Wales: Cumulative Impact Policies (CIPs). CIPs were first described in guidance relating to the Licensing Act, 2003, and by 2014 there were over 100 LGAs across England and Wales with CIPs (Morris, 2015). They allow licensing authorities to designate a specific area or areas (referred to as Cumulative Impact Zones (CIZs)) within LGA boundaries as requiring a more stringent licensing policy to tackle alcohol related harms that are assumed to be linked to high outlet densities. CIPs are intended to shift the burden of proof during licensing decisions by establishing the legal presumption that contested applications for premises located within CIZs will be refused unless the applicant (i.e. retailer) can demonstrate how they will avoid compromising each of four licensing objectives encoded in English law. These objectives are (i) prevention of crime and disorder; (ii) public safety; (iii) prevention of public nuisance and (iv) protection of children from harm. In contrast, where CIZs are not in force, the legal presumption is that licence applications will be granted unless an opposing party can demonstrate that one (or more) of the objectives would be compromised (Home Office, 2012).

Unlike in Scotland, there is no licensing objective for England and Wales that deals specifically with public health protection (Fitzgerald, 2015). However, licensing authorities can choose to use health justifications to support their case for creating CIPs, and so CIPs have been considered a means by which English Public Health authorities can become involved in alcohol licensing policy, even without a specific public health licensing objective

(Martineau et al, 2013a, Andrews et al, 2014).

As CIPs appear to strengthen legal powers to reject alcohol licence applications, and are justified in terms of harms caused by high alcohol retail density, it might be assumed that their primary purpose is to reduce or cap outlet density by facilitating refusals of new applications for licences. However, analysis of Home Office data found that 86% of licence applications in CIZs were granted in 2014 (Morris, 2015). The precision of these early estimates has been questioned by Foster and Charalambides (2016) but their own investigations also confirm that new licences are regularly granted within CIZs.

If CIPs are not being used to cap the number of alcohol licences, this raises important questions about the purpose of the intervention. Hence, research that aims to provide a richer understanding of the intervention and its mechanisms for achieving impact is appropriate. Guidance on evaluating complex interventions have emphasised the importance conducting (often qualitative) research to help better understand intervention aims, mechanisms and pathways to impact (Craig et al., 2008). Local practitioners have also been found to particularly value evidence from local case studies (McGill et al., 2015).

We therefore conducted qualitative case studies of purposively selected English LGAs. These case studies allowed us to map variations in the purpose, nature and implementation of CIPs. We aimed to improve understandings of what CIPs are, what they are intended to achieve and how they can vary. Specifically we used the findings to address the following questions: (i) what do local stakeholders consider to be the aims or purpose of CIPs in their areas?; (ii) do stakeholders consider CIPs in their area to be mechanisms for reducing alcohol availability?; and (iii) are the CIPs considered to have other uses besides or instead of modifying

availability? The findings have important implications for policy makers seeking to determine whether this intervention can be tailored to tackle alcohol related harms in different localities, and it has implications for future attempts to understand and evaluate the impacts of local alcohol interventions such as CIPs.

Method

Our approach reflected key principles of comparative case study design: using a multi-faceted approach to develop a pluralistic understanding of a phenomenon in a 'real-life' context (Crowe et al., 2011). Our intention was to understand both how CIPs were formally described by different LGAs in key policy statements, but also to gain a richer understanding of how key local policy stakeholders developed, understood and implemented the intervention. Case studies are particularly useful for understanding topics in which the boundaries between the phenomenon of interest and its context – in this case the CIPs and the local policy environments from within which they are enacted – are not easily definable because of different and potentially contested meanings and assumptions (Yin, 2003).

Recruitment and data collection

Researchers from universities situated in four English regions (North West, North East, South West, and London) used local knowledge and contacts to select five LGAs that had reputations for being active in developing local policies around alcohol licensing, harm prevention and reduction. We felt that LGAs that were active in this policy area would be more willing to participate and would provide richer data about the different ways CIPs could be implemented. However, this meant that LGAs that made alcohol harm reduction a lower priority (perhaps because other issues in their area were considered a greater priority) were

not a focus of the study. LGAs that pursued other activities to reduce alcohol harms but did not have CIPs were not included.

The LGAs that did participate included two regional cities, a regional town, an area that included small towns and rural areas, and a small borough in London. All contained a mixture of disadvantaged and more affluent sub-areas as well as sub-areas that were considered night time economy destinations (these were larger in the more urban LGAs). Besides implementing CIPs, the five LGAs also implemented other interventions affecting the local 'alcohol environment' including community safety activities, further regulation of the night time economy and encouragement of voluntary initiatives involving licence-holders.

Researchers conducted semi-structured individual and/or group interviews with local stakeholders involved in the implementation of CIPs and/or delivery of LGA alcohol strategies (see table 1 for study sample). As a minimum we required each case study to include interviews with public health and licensing leads and documentary analysis of local licensing policies. Additional interviews, focus groups and other fieldwork depended on local availability: the researchers set no *a priori* limit on the amount or type of additional data that could be collected if considered relevant to the research topic. In two areas, ethnographic methods were employed to observe licensing policy in practice, including observations of licensing meetings and ongoing contact with key informants within the context of their work practices in alcohol licencing (see notes to Table 1). Most interviews were at least an hour in length and conducted face-to-face, although telephone interviews were conducted when necessary.

The study was approved through ethics committees at the London School of Hygiene & Tropical Medicine, University of Sheffield, and University of Lancaster. Informed consent, anonymization and data security conformed to institutional ethical standards.

Analysis

Through an inductive process, key themes were identified to map CIPs and enable comparisons between cases. A structured framework was developed to enable researchers from different centres to record descriptions of their case studies in a format that aided cross-case comparisons (see supplemental file). We used formal statements of licensing policies to identify the stated aims of each CIP and then drew on fieldwork data to further unpick stakeholder understandings of how each CIP was implemented in practice. One researcher led on identifying key themes for comparison, with researchers from the other centres cross-checking, commenting and revising. These final list of key themes included policy aims, CIZ geographies, availability, targeting of premises and trade responses.

Findings

Table 1 summarises the study sample. Across the five case studies, 48 local practitioners participated in interviews or focus groups. Licensing and public health practitioners participated in each case study. Three case studies included interviews sampled from a broader set of stakeholder groups such as alcohol and other services, community safety, police and trading standards, ambulance, education, housing and councillors. Observational and ethnographic fieldwork included a wider number of stakeholders from different backgrounds.

Table 1: Case study samples

English region where LG case study located	Document analysis	Ethnog-raphic	In depth interview	Focus group (participants)	Participating stakeholders
London	Y	Y*	1	3 (n=10)	Licensing, Public health, Trading standards, Council
North West	Y	Y*	10	1 (n=5)	Licensing, Public Health, Trading standards, Police, Ambulance, Education, Housing.
North East	Y	N	7	0	Public health, Alcohol services, Licensing, Community safety, Police, LA information analyst Trading standards
South West	Y	N	2	0	Licensing and alcohol strategy.
South East	Y	N	13	0	Licensing, Community safety, Police, Public Health, Alcohol services, Homeless services, Council

*Ethnographic fieldwork: 6 month periods that included shadowing licensing and public health practitioners, attending meetings and licensing hearings and conducting semi-structured and unstructured discussions with stakeholders from licensing, public health, NHS, trading standards, community safety and police who were aware of the researcher's status.

CIP variation across localities

The purpose of CIPs

Statements of local licensing policies varied in terms of reported aims and justifications for CIPs. None of the case study policy statements explicitly stated that CIPs were intended to reduce or cap the number of licensed premises within CIZs, although some participants depicted their CIP as a response to a perceived recent increase in outlet density. All the LGAs stated that their CIPs were intended to support the four national licensing objectives relating to crime and disorder, public safety, public nuisance and child protection, although case studies varied in the degree of emphasis placed on different objectives. The objective around child protection received less emphasis in some statements: in London, licensing officials stated specifically that other policies already dealt with this issue.

Policies tended to have little or limited emphasis on public health concerns. Some CIP statements referred to health issues that intersected with licensing objectives: the North East authority referred to "*increased alcohol-related crime and violence and under-18 alcohol-specific hospital admissions*." The London LGA referred to a broader range of health statistics that included ambulance call outs, acute hospital admissions and chronic alcohol related conditions. Nonetheless the social harms targeted in the licensing objectives remained the primary focus.

However, some participants described how over time their CIPs had come to be viewed as a policy that could be allied to urban transformation and regeneration goals.

> *So when they* [CIZs] *were brought out it was for completely different reasons to what we want to do today in terms of changing the town…Originally when they were brought out it was purely to address crime. They have not been created for the purpose they are being used today.* Focus group, Licensing, North West.

> [Licensing]: *it* [CIP] *is now starting to contribute to regeneration, because that's one of the big things that always comes up - oh, if you have cumulative impact or a restrictive policy then that stops regeneration because cities, especially, need the late night economy. I think we would argue against that, that actually it can sort of go the other way.* [Public Health]: *in* [this area] *what they call regeneration is a good place to live, not a good place to party.* Focus group, Public Health and Licensing, London.

Conversely, participants from another area felt that CIZs would be unsuitable for an area undergoing regeneration.

> *In this area, which was run down, it was decided not to bring in a CIZ because of worries it may hamper or stall any regeneration.* Interview, Licensing, South West.

We found little evidence of conflicting opinions between stakeholder groups, which perhaps reflects our sampling of areas where multi-sectoral action around alcohol harms had been promoted: notably between licensing, public health and the police. In focus groups, participants working within different professions tended to corroborate rather than contradict one another. However, one London focus group that included Licensing and Public Health representatives who worked in partnership did discuss differences in their viewpoints. Whilst they agreed with one another that a policy focusing on alcohol outlet density '*probably wasn't nuanced enough',* a Public Health participant then went on to add *'But it's a good start, to hit density, I would say, if you can just do one thing, yeah.*' His local Public Health team routinely opposed new licence applications in CIZs on the grounds that increased alcohol availability increased short and long-term health risks. However a participant from

Licensing responded with the view that without a statutory health protection licensing objective, the presumed link between outlet density and population-level morbidity was not sufficient grounds to reject specific licence applications. This prompted the following discussion:

> [Public Health]: *And I guess if we do get a public health licensing objective and a cumulative impact policy, all we need to do....* [Licensing]: *Yeah.* [Public Health]: *…is prove that it increases the density, which obviously it does*. [Licensing] *Yeah.* Focus group, Public Health and Licensing, London.

CIZ Geographies

The CIZs differed in size across the cases studied: from small areas around a single building or street to entire city centres. This difference in spatial scale could reflect the size of the geographical area in which alcohol outlets were concentrated (which differed by LGA). Licensing authorities could also draw multiple CIZs: some started with a single area and subsequently added more (the most in our sample was 7 CIZs within an LGA boundary).

All five case study LGAs placed CIZs around areas perceived to be popular night spots used not only by local residents but also (and at times predominantly) by non-local people. These varied in size: two LGAs had large zones in their city centres and a third LGA took a similar approach with its town centre. A fourth LGA that covered small towns and rural areas limited its CIZs to relatively small sub-areas in two town centres. The London LGA placed several relatively small zones around sub-areas that attracted visitors at night. Besides covering town and city centres, the four urban LGAs we sampled also had CIZs in less central areas where clusters of outlets were perceived to be leading to disturbance of local residents. These less central zones tended to be in relatively disadvantaged areas.

Participants from several areas stated that the process of drawing CIZ boundaries was informed by quantitative and geographical evidence on local outlet locations, crime and health statistics. However, even in such cases, licensing practitioners also emphasised the importance of tacit knowledge about the area and beliefs about what boundaries would be politically feasible.

> *It was very much about density of premises initially, and then what we did is that we looked at other data, whether it was crime data, ambulance call outs, complaints that, that we had, but also local knowledge from, whether it was officers or members, and then tried to sort of like formulate the map accordingly... there were discussions, for instance, like why don't we just go whole borough. And, ah, you know, why don't you put this sort of area in…but, you know, we didn't want to put them in and then find that we've got no evidence and then that basically means that we lose what we did want, so I think we reflected as far as we could but we always had one eye on the fact that we might have to defend it. And, you know, that's the kind of cut off.* Focus group, Licensing, London

Availability

Although most participants maintained that CIPs were not used to reduce or cap physical availability, the North East authority did have smaller "*Special Policy Areas*" where "*applications will normally be refused*." In contrast to the Special Policy Areas, participants and policy statements often made explicit reference to licences continuing to be granted in CIZs.

> *I think there was a little bit of public feeling that a Cumulative Impact Policy stops any new premises coming. We haven't actually refused an application because of our Cumulative Impact Policy, what we have done, I think it's increased the engagement between licensees and its partners is what I think it's personally done*. Interview, Licensing, South East.

Licences were refused in other case study CIPs, but even in these Licensing practitioners displayed an apparent willingness to accept and even encourage some types of application.

> *You know if you have a well-managed premise that puts a lot of things in place, and doesn't have their customers walking out and vomiting or falling over, you know what I mean? Then you can, you can stay there. You can have as many of those premises as you'd like*. Interview, Licensing, London.

Most case study CIPs aimed to reduce the temporal availability of alcohol. Some policies were more detailed than others. For example, the South East and North West authorities did not specify opening hours in their policies but did target nightclubs and late opening licensed fast food takeaways. In contrast, the London and North East policies included frameworks detailing what hours of trade would be unacceptable for different types of premise, with greatest restrictions around the 11pm to 6am period:

> *We've also got like a framework of hours so if anybody wants to open up in the city we tell them that these are the hours that we normally like.* Interview, Public safety, North East.

The South West CIP made no reference to temporal availability and a Licensing participant stated that issues around opening times were already "covered in licensing procedures" that were implemented independently of CIPs.

In terms of economic availability, a Licensing Officer from the London area identified the sale of cheap alcohol as a practice they hoped could be discouraged:

> *Pints £2, you know? Double shots, do a top up for 50p, right? You know what I'm talking about.* Interview, Licensing, London.

However, they did not provide details of how in practice their CIP could be used to target premises selling cheap alcohol. The North East authority were also concerned about cheap sales and they provided more details of how they negotiated applicants' sales prices for a small number of premises on a case by case basis. The following quote recounts the first occasion this occurred (the licence application referred to was eventually granted, and the process was then emulated for other applications):

> *what happened was a previous entrepreneur of this city knocked on our doors and said I would like to open a bar…[in a CIP area]…and we said oh not that keen on that or we may not be and he said well I'll give you some minimum pricing by mutual agreement so we sat down with him and we came up with a series of minimum pricing which would be for example £3.50 for a bottle, £3.50 for a pint err £4.50 for a glass of wine, £18.00 for a bottle of wine etc. etc*. Interview, Licensing, North East.

Targeting of on-licence premises

CIPs from our case studies specifically targeted either off- or on-licence premises, or covered both. With respect to on-licence applications, "*vertical drinking*" bars (where customers are not obliged to drink seated) were a common target for CIPs. Nightclubs were also targeted in relation to concerns about late night public order. Large premises, variously defined, were targeted in some policies.

Exceptions were made if the venue was considered to prioritise other types of consumption over alcohol. A London Licensing participant believed the CIP encouraged more applications from arts, food and coffee led establishments:

> *There's a new theatre. There's a number of galleries that have opened up…And now suddenly we're seeing some, you know, some quite good quality applications coming in for, you know, more kind of sort of like restaurant, café-bar.* Focus group, Licensing, London.

North East participants emphasised their preference for what were sometimes described as "*quality*" establishments, including a greater proportion of restaurants and premises that catered for family and elderly customers. However, applications for bars that sold food and catered to some degree for children could be opposed in some areas if the primary purpose was still seen to be the consumption of alcohol. In the South West, a Licensing Officer hypothesised that an alcohol licence for a lap dancing bar might be granted, as such venues were not perceived to encourage alcohol-related problems.

Targeting of off-licence premises

Budget stores, takeaways; small independent off-licences, late night or 24 hour off-licences and supermarkets were all identified by participants from one or more case study as unlikely to receive licences in their CIZs. Different types of premise were associated with different problems.

Small independent businesses and discount stores were repeatedly depicted as undesirable because they were perceived to be alcohol-led (and frequently associated with low cost products) or more generally detrimental to the local area and its residents because of the poor image that certain types of shop were perceived to project.

> Public Health*:…ten bags of crisps and, you know, a wall of low cost alcohol.* Licensing: *Pound shops*. Public health: *Yeah, just selling rubbish – just with an alcohol licence.* Focus group, Public Health and Licensing, London.

Implementers spoke of using CIPs as part of a broader strategy to remove such shops and so improve the area.

> *That's the plan in my head and eventually we will get to a point where we either lift up the poorer operators or kick them out of business and then that changes the dynamic a little bit in those areas.* Interview Licensing, North West.

Supermarkets, on the other hand, could be problematized for selling inexpensive alcohol, often having long hours of sale, and having the financial and legal resources to challenge licensing decisions in court.

> *My frustration around some of the bigger alcohol retailers - that we seem to be bashing the small off-licences and small-on licences but we are just not in the position to tackle the bigger ones…selling alcohol as loss leaders and [where] alcohol is too cheap.* Interview, Police, North West.

However, both North East and London participants described examples of their licensing authority successfully challenging late night licence applications from major supermarket chains.

Response of Licence Applicants

Participants often discussed how licence applicants responded to CIPs. Some applicants sought and took advice from local authority representatives, particularly those from Licensing and the police, to help them produce licence applications that were in keeping with the local policy. A number of participants, again typically from Licensing or the Police, considered this to be a desirable process of "engagement" that led to better quality applications that were more likely to be granted.

> *Some of them have actually been very good. We had one* [application] *that was like a, that was a bar licensed till 2.00 am that's been taken over, it's like a Nepalese restaurant. So he actually listened to my advice and reduced the hours, got rid of a whole bunch of conditions, and put like the alcohol as ancillary to food, because he only wants to do table service*. Interview, Licensing, London

This engagement could occur before or after an application was submitted. Participants at times gave favourable accounts of applicants who abandoned initial requests for late opening hours and who adopted measures taken to be signs of responsible management such as

trained door staff, CCTV, limiting visibility of alcohol within the premise, age verification of customers, and willingness to take part in voluntary alcohol initiatives.

Without this kind of engagement, participants believed that applicants would be more likely to produce unsuitable applications, see them rejected and then consider taking the Licensing Authority to court. LGAs varied in their willingness to risk expensive court cases but they tended to agree that it made sense to encourage a co-operative rather than adversarial approach to dealing with applicants.

> *What tends to happen over here though is there is a lot of informal conversations with the police and licensees to make sure that they aren't going to be refused, so they get the message earlier rather than coming, getting refused, then it goes to appeal and then there's that whole rigmarole*. Interview, Licensing, South East.

However, some participants described concerns about applicants learning how to mask their intentions for a proposed business: for example, depicting cocktail bars as coffee-led; vertical bars as child friendly; having premises change focus in the evening from café to bar and from bar to club; vague applications, and making use of licences for "*special events*" to allow increased alcohol-led retailing.

> *These really big* [art] *studios, they wanted beer and wine or whatever, they have a little café. Which is like 30 or 40 people, again, as an amenity. So I helped him with that, because the original application was just like a nightmare, I think it was done by some solicitor who - and everybody went crazy - because it was an application for a nightclub. It was basically, it was saying we're going to do live music, recorded music, alcohol. They didn't explain, they didn't have any conditions*. Interview Licensing, London.

Hence, applicants were depicted by practitioner stakeholders as responding to CIPs in a range of ways that could include co-operation and compliance, legal challenges and misleading or uninformed applications.

Discussion

CIPs are increasingly being implemented by English LGAs but there remains a lack of clarity regarding what they are intended to achieve and how they will achieve it. Our case studies found that five LGA's implemented CIPs with the aim of supporting nationally set licensing objectives, most consistently those objectives around crime and disorder. In comparison, the CIPs made little or no mention of long term health problems related to alcohol affecting the wider population – perhaps reflecting the lack of a statutory public health licensing objective in England. Local practitioners between case study areas also held differing opinions as to whether CIPs were a facilitator or barrier for urban regeneration goals in their particular area.

One finding that unites all the CIPs we studied is that none of them aimed to reduce or cap the number of licenced premises in their area. It is possible that some LGAs outside our sample do use CIPs for this purpose. However, our case studies identified a different intervention, Special Policy Areas, which were implemented on a much smaller geographical scale to prevent further increases in spatial outlet density.

CIZs, on the other hand, were places where a perceived 'wrong sort' of licence application would face rejection, but where there was also a 'right sort' of application that was still approved. Licensing authorities had leeway to define for themselves which kinds of application would be treated favourably or unfavourably. Some favoured restaurants, cafes and arts venues over vertical drinking bars and clubs. Several discouraged late night alcohol-

led on-licence venues. Late night and small independent off-licences could also be subjected to more stringent licensing requirements. Specific managerial practices around security, trading standards and promotion of alcohol could be taken into account during licensing committee meetings and negotiations. We identified some evidence of LGAs seeking to restrict economic availability by providing guidelines on minimum prices; and some policies sought to restrict spatial availability by rejecting applications for large premises. We also note that CIPs do not prevent the 'wrong sort' of premise from opening outside CIZs, raising the possibility of spillover effects.

Research implications

Our findings suggest that characterising CIPs as successful or unsuccessful strictly on the strength of whether they lead to reduced outlet density or reductions in licences granted is likely to be misguided (Morris, 2015). Even if alcohol outlet density turns out to be largely unaffected by CIPs, the intervention could still hypothetically have an impact either alone or in combination with other interventions. Although de Vocht et al's (2015) study of licensing policy 'intensity' did not set out explicitly to evaluate CIPs, it did find evidence of comparatively better alcohol related health outcomes amongst LGAs that had implemented CIPs and rejected licence applications. These findings help make the case for an evaluation of CIPs with appropriate social and health outcomes but also consideration of unintended consequences such as spill over.

Future research could usefully test assumptions about whether a high street shift in favour of particular kinds of alcohol outlet and specific managerial and other retail practices can lead to reductions in alcohol related social and health harms (McShane and Kneale, 2011). The lack

of robust evidence addressing this issue has been commented upon (Gmel et al, 2015). Research in this area could begin by comparing premises that are 'alcohol led' and those that are led by other forms of consumption, as this distinction seems to be important for licence decision-makers.

However, a more nuanced understanding of neighbourhood 'alcohol environments' is also desirable so that we can critically examine this alcohol led/not-led distinction. Retail practices and outlet types have been the focus of previous research from various disciplines including geography, anthropology and sociology (Bøhling, 2015; Chatterton and Hollands, 2003; Eldridge and Roberts, 2008; Jayne et al., 2010; Shaw, 2014; Taylor and Falconer, 2014; Valentine, 2007): such research could inform evaluations seeking to examine changes in the alcohol environment (Gruenewald et al., 2002). The relationship between outlet type and area deprivation could also aid understanding of how changes to the alcohol environment relate to health inequalities and urban regeneration goals (Shortt et al., 2015).

Some of our participants thought that larger businesses had more resources to prepare, negotiate and if necessary take legal action to obtain their licences. Future research could usefully compare the experiences and impacts of smaller and larger businesses. This could apply to both on and off trade retailers, testing the hypothesis that licence applications from larger businesses could be more likely to be granted, and considering the health and social consequences.

Implications for policy and practice

Our comparative case study has found that CIPs vary greatly in terms of the size, number and locations of CIZs and can also vary in policy content. CIZs differ both within and between

LGAs. CIPs may be described as a flexible policy tool that can be delivered in different forms and at different levels of intensity in different contexts. However, a more critical framing could characterise CIPs as an instrument that, in practice, lacks a specific or consistent means of addressing alcohol harms caused by over-provision. As decentralisation of health services (including public health provision) is an ongoing subject of controversy, the choice to cast local variation in either a positive or negative light can have political connotations: for example the UK Government's 2012 Alcohol strategy (HM Government, 2012) emphasised local variation but has been criticised for not delivering sufficient national level regulation (Alcohol Health Alliance UK, 2013; Foster and Charalambides, 2016).

Furthermore, the research literature on area and community level public health interventions includes differing viewpoints on the desirability of local variation. For example, Hawe and others (Bisset et al., 2013; Hawe, 2015; Pluye et al., 2004) have argued that variation is not only an inescapable feature of interventions delivered in the context of complex systems, but that appropriate local-level tailoring and adaptation are important for maximizing effects and encouraging sustainability.

Local variation has also been linked to variations in quality of service potentially leading to geographically unequal health outcomes (de Vocht et al., 2015). Reliance on local solutions for the national problem of alcohol related harms risks leading to unequal investment, delivery and effectiveness of local strategies. However, local alcohol strategies (such as CIPs) and proposed national-level availability interventions (such as minimum unit pricing (Holmes et al., 2014)) are not mutually exclusive. Governments have the option of choosing both with the aim of benefiting simultaneously from strategies tailored to local contexts, alongside the kinds of nationally enforced availability restrictions that have been found to be effective in

reducing alcohol harms across different contexts (Martineau et al., 2013b). The creation of a statutory licensing objective concerned with the protection of public health has also been advocated as a means of encouraging LGAs to refuse licences on account of the presumed negative impact on population health. Foster and Charalambides (2016) have argued that current English licensing legislation could be utilized more to restrict alcohol availability, but they also make the case for a health licensing objective and report that there is strong support for its introduction amongst relevant local stakeholders.

Limitations

Our comparative case study approach necessarily comprises a trade-off between depth and breadth of analysis. The five sites in our current study give a sufficiently broad basis for understanding and mapping diversity and in a separate publication we have complemented this with a more in-depth case study (Grace et al., 2016). Our sampling strategy for the current study focused on LGAs known to us to be particularly active in their approach to tackling alcohol related problems, although the prominence of CIPs in local alcohol strategies still varied between case studies. The sampling strategy involved subjective criteria on the part of researchers and the sample is not intended to be representative. Our decision to anonymise case study areas limits the amount of contextual detail we can include about each area.

For pragmatic reasons, different researchers conducted fieldwork in different localities, tailoring their fieldwork to participant availability and local structures. Potential disadvantages relate to whether contrasting findings reflect in some way interviewer effects or methodological issues that differ between study sites. In all the case studies, licensing and public health officials were interviewed (arguably the core stakeholders for the delivery of

this intervention), and the different researchers maintained frequent contact (face-to-face, teleconferences and email) at all stages of the study from planning, through fieldwork, to analysis and write up – with the aim of using differences in researcher perspectives to enrich rather than limit the study.

Conclusion

Previous research and commentaries on CIPs have at times described the policy as a potential mechanism for enabling public health goals to influence alcohol availability, and as a means of reducing or capping alcohol outlet density at a local level. Our qualitative findings suggest that public health concerns can influence CIPs through modifying the temporal, economic and/or physical availability of alcohol, with the exact mix dependent on the priorities of key local stakeholders. CIP policies are also used as part of an attempt to shift alcohol retail environments away from alcohol led, vertical drinking establishments and towards outlets that present alcohol consumption as subsidiary to other forms of consumption such as coffee, arts, meals and groceries. This is a shift in the presentational context of alcohol for sale. With the active encouragement of some local authorities, it is currently taking place in high streets and neighbourhoods around the UK and its population health impacts need to be better understood.

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