

Factors influencing public health engagement in alcohol licensing in England and Scotland including legal and structural differences: comparative interview analysis

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Abstract

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Background: Greater availability of alcohol is associated with higher consumption and harms. The legal systems, by which premises are licensed to sell alcohol in England and Scotland, differ in several ways. The 'Exploring the impact of alcohol licensing in England and Scotland' study measured public health team activity regarding alcohol licensing from 2012 to 2019 and identified seven differences between England and Scotland in the timing and type of activities undertaken.

Objectives: To qualitatively describe the seven previously identified differences between Scotland and England in public health approaches to alcohol licensing, and to examine, from the perspective of public health professionals, what factors may explain these differences.

Methods: Ninety-four interviews were conducted with 52 professionals from 14 English and 6 Scottish public health teams selected for diversity who had been actively engaging with alcohol licensing. Interviews focused primarily on the nature of their engagement ($n = 66$) and their rationale for the approaches taken ($n = 28$). Interview data were analysed thematically using NVivo. Findings were constructed by discussion across the research team, to describe and explain the differences in practice found.

Findings: Diverse legal, practical and other factors appeared to explain the seven differences. (1) Earlier engagement in licensing by Scottish public health teams in 2012–3 may have arisen from differences in the timing of legislative changes giving public health a statutory role and support from Alcohol Focus Scotland. (2) Public Health England provided significant support from 2014 in England, contributing to an increase in activity from that point. (3) Renewals of statements of licensing policy were required more frequently in Scotland and at the same time for all Licensing Boards, probably explaining greater focus on policy in Scotland. (4) Organisational structures in Scotland, with public health stakeholders spread across several organisations, likely explained greater involvement of senior leaders there. (5) Without a public health objective for licensing, English public health teams felt less confident about making

objections to licence applications without other stakeholders such as the police, and instead commonly negotiated conditions on licences with applicants. In contrast, Scottish public health teams felt any direct contact with applicants was inappropriate due to conflicts of interest. (6) With the public health objective in Scotland, public health teams there were more active in making independent objections to licence applications. Further in Scotland, licensing committee meetings are held to consider all new applications regardless of whether objections have been submitted; unlike in England where there was a greater incentive to resolve objections, because then a meeting was not required. (7) Finally, Scottish public health teams involved the public more in licensing process, partly because of statutory licensing forums there.

Conclusions: The alcohol premises licensing systems in England and Scotland differ in important ways including and beyond the lack of a public health objective for licensing in England. These and other differences, including support of national and local bodies, have shaped opportunities for, and the nature of, public health engagement.

Further research could examine the relative success of the approaches taken by public health teams and how temporary increases in availability are handled in the two licensing systems.

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Plain language summary

When alcohol becomes more widely available, harms tend to increase. In England and Scotland, this availability is controlled by local councils. They 'licence' shops, bars and other venues to allow them to sell alcohol. Local health teams, including doctors, often advise councils on licensing. In earlier work, we found seven differences in what Scottish and English health teams do on licensing.

In this study, we explore these seven differences and why they came about. To do this, we interviewed 94 professionals working in public health across both countries.

Scottish health teams got involved in licensing earlier than in England. This was partly because of when certain laws changed. Also, they were helped earlier by national organisations that try to reduce harm from alcohol. Scottish teams were more involved in local policies on licensing. This was probably because these policies changed more often in the Scottish system. Scottish teams involved the public more. This was partly because Scottish councils must set up 'local licensing forums'. Scottish teams also objected more often to licence applications. They generally felt that they could be more actively involved, because of a law in Scotland that says licensing must protect public health. This law does not apply in England.

In England, health teams were more likely to talk to businesses that wanted licences. They were less likely to try to block applications. When they agreed changes to applications with businesses instead of objecting, fewer formal licensing meetings were needed. This was not the case in Scotland. Also, Scottish teams did not feel it was okay for them to talk to businesses.

In summary, there are important differences in licensing law between Scotland and England. These matter for how health teams in the two countries engage with local councils, businesses and the public on licensing matters.

Background

Alcohol consumption in the UK remains high when compared to levels of consumption elsewhere in the world.¹ There is consistent evidence to suggest an association between increased availability of alcohol and higher rates of alcohol consumption, and associated harms;² this includes physical availability, which relates to alcohol outlet density,^{3,4} and temporal availability, which related to hours of sale.^{5,6} Restricting alcohol availability is therefore a plausible means of reducing harm.² However, achieving a reduction in harms through restrictions in availability remains challenging due to high baseline availability levels and the limitations of local regulatory and legislative measures.⁷

Many countries use some form of premises licensing system to regulate alcohol availability, by granting a licence to premises to permit and put conditions on the sale of alcohol. Scotland and England/Wales have independent systems which both assign responsibility for licensing to local authorities.⁸ The systems are governed by Scottish and English laws respectively, which set statutory objectives for licensing focused on preventing harm to children, crime and disorder and public nuisance, securing public safety, and in Scotland only, 'protecting and improving public health'. In both systems, local public health stakeholders have a statutory role and attempt to influence alcohol premises licensing using a variety of approaches and degrees of effort. These include, for example, engaging local authority stakeholders on licensing policy or seeking to influence decisions on applications.⁹⁻¹⁵

The absence of a health-focused objective for licensing in England (unlike in Scotland) is seen by many English public health teams (PHTs) as hindering their efforts to influence licensing,^{14,16,17} and is often perceived as diminishing the legitimacy of public health stakeholders in relation to other statutory bodies. This also makes it more likely that the admissibility of health evidence will be challenged in licensing decisions, where a case can be made that such data are irrelevant to the other objectives. Nevertheless, even without a public health objective, many PHTs in England have sought to work closely with other licensing stakeholders, such as the police, to try to boost their influence on both decisions and policy.^{13,14} In Scotland, however, licensing stakeholders also report difficulties applying the public health objective, especially when objecting to individual applications.^{9,18} We are unaware of any comparative studies that have examined how legal or structural differences between these two licensing systems (other than the extra objective in Scotland) might affect public health practices. The explicit inclusion of public health improvement, as a decision criterion in licensing, is relatively unique globally – though some licensing jurisdictions (including most Australian states and territories) have a requirement to consider 'harm minimisation', which may include public health.^{19,20} We are not aware of any study outside of the UK focused on how public health stakeholders engage with alcohol premises licensing.

As part of the exploring the impact of alcohol premises licensing in England and Scotland (ExILEnS) study,²¹ we previously compared public health practices in engaging with the licensing system in England and Scotland. We conducted structured interviews and documentation analysis to capture the nature and intensity (level or degree of engagement or leadership) of relevant public health activity in 39 local government areas in England and Scotland from 2012 to 2019. We developed and systematically applied a measure of PHIAL (the Public Health engagement In Alcohol Licensing measure)²² to the data, to generate a quantitative measure of activity under each of 19 different activity types in 6 categories for each 6-month period in each of the 39 areas. These measurements enabled comparison of PHT activity in Scotland and England over the whole data set, and we have previously reported seven differences across both type and level of activity:²² (1) generally higher levels of activity in Scotland especially from 2012 to 2014; (2) a step-change increase in activity in English PHTs from 2014 onwards; (3) higher levels of activity in Scotland around efforts to input to local licensing policies; (4) greater levels of involvement of senior leaders (e.g. Directors of Public Health) in Scotland; (5) greater diversity of approaches around responding to licence applications in England, with English PHTs being more likely to have sought to influence licence applications pre-submission, attempted to shape submitted applications, or been involved in licence reviews (a process by which a licence can be suspended or

revoked); (6) more frequent involvement of PHTs in Scotland in making or leading objections to licence applications; and (7) more activity in Scotland around initiatives to involve communities in efforts to influence licensing.²² This previous paper was focused on outlining the development of the PHIAL Measure, and while the seven differences are clear in the PHIAL scores that we report there, it was beyond the purpose of that paper to seek to describe or explain those differences.

In this paper, we therefore draw in greater depth on qualitative data from the structured interviews and on additional in-depth interviews to more fully describe and explain the seven differences, from the perspective of public health stakeholders. To orientate the reader, we firstly provide a comparative description of the two licensing systems including legislation and related structures in Scotland and England before outlining our methods in detail and then covering each of the seven differences in turn. Our key research question therefore is:

- What factors, including legal and structural differences, may explain previously identified differences in public health engagement in alcohol licensing in Scotland and England, from the perspective of public health stakeholders?

Licensing systems in Scotland and England

Scotland and England are both part of the UK of Great Britain and Northern Ireland. Scotland has devolved authority to make decisions over certain matters, including alcohol licensing. In both nations, local licensing committees make the final decision on new or amended licences, guided by the licensing objectives (see below). Various stakeholders (known as 'Responsible Authorities' in England or 'Statutory Consultees' in Scotland) are routinely informed of licence applications. In response, these stakeholders can seek to influence licensing decisions, for example, by formally suggesting amendments to applications (making a 'representation') or by formally opposing the granting of a licence (making an 'objection').

Normally, outside of specific areas (see below and [Table 1](#)) the licence will be granted unless a convincing case is made, with supporting evidence, that the proposed licence would undermine one or more of the licensing objectives. Scotland and England have their own distinct licensing legislation, local government structures and alcohol policies. Notably, in Scotland, all applications for new premises licences or major variations to existing licences are considered by a meeting of the Licensing Board who may choose to accept or reject the application. In England, the Licensing Committee only meets to consider an application if a representation or objection against the licence has been submitted; otherwise it is granted without a meeting. Legislation heralding major reforms to the licensing system in each nation came into effect in 2005 for England and Wales²³ and 2009 for Scotland,²⁴ later supplemented and amended by further guidance and legislation.

[Table 1](#) outlines key differences and similarities between the two systems.

TABLE 1 Comparison of alcohol licensing systems and structures in England and Scotland

Issue	England	Scotland
National legislation	Licensing Act 2003; Police Reform and Social Responsibility Act 2011 Policing and Crime Act 2017 ^{23,25,26}	Licensing (Scotland) Act (2005) Alcohol etc. (Scotland) Act (2010). Criminal Justice and Licensing (Scotland) Act (2010) Alcohol (Minimum Pricing) (Scotland) Act (2012) Air Weapons and Licensing (Scotland) Act (2015) ^{24,27-30}
Relevant statutory guidance	Home Office Section 182 guidance: 'a key medium for promoting best practice, ensuring consistent application of licensing powers across England and Wales and for promoting fairness, equal treatment and proportionality.' ³¹	Scottish Government Guidance for Licensing Boards under section 142 of the 2005 Act approved on 7 March 2007. A consultation exercise has been completed on updated guidance, which is expected in 2022.
Local government licensing bodies	Licensing Authority (n = 350) ³²	Licensing Board (n = 40)
Alcohol licence applications decision-making body	Licensing Committee comprising local elected politicians who are members of the local government (also known as the 'local authority' or 'local Council').	Licensing Board, a public body separate from the local government body (the 'local authority' or 'Council'), albeit supported and resourced by local government, and with membership comprising local elected politicians ('Councillors') who are nominated by the local government body to sit on the Licensing Board.

continued

TABLE 1 Comparison of alcohol licensing systems and structures in England and Scotland (*continued*)

Issue	England	Scotland
Licensing objectives	<p>Four objectives:</p> <ol style="list-style-type: none"> (1) The prevention of crime and disorder (2) Public safety (3) The prevention of public nuisance (4) The protection of children from harm 	<p>Five objectives:</p> <ol style="list-style-type: none"> (1) Preventing crime and disorder (2) Securing public safety (3) Preventing public nuisance (4) Protecting and improving public health (5) Protecting children and young people from harm
Public and health bodies with statutory involvement in local licensing decisions	<p>'Responsible Authorities' are notified of licence applications: local government teams and departments (licensing, environmental health; trading standards; planning; child protection, the Director of Public Health); police; fire and rescue; health and safety authority; Home Office immigration enforcement.</p>	<p>'Statutory Consultees' are notified of licence applications: the local government body, any community council within whose area the premises are situated, the relevant local Health Board, the Chief Constable, and the local fire authority.</p>
Local policy statements and other reporting	<p>Statement of Licensing Policy (SLP): usually established every 5 years. During each 5-year period, SLP must be kept under review and authorities may publish a revised SLP during this period. If a revision is made to the SLP, once it is published with the revision a new 5-year provision commences. The renewal interval for SLPs was moved from 3 to 5 years after 2011.²⁵</p>	<p>Licensing Boards are required to publish a Statement of Licensing Policy within 18 months of local government elections normally held every 5 years.²⁸ During each 5-year period, the SLP must be kept under review and boards may publish a supplementary SLP during this period. The renewal interval for SLPs was moved from 3 to 5 years after 2015.²⁸ Licensing Boards are also required to publish an annual functions report stating how the Board has had regard to the licensing objectives and their policy statement, a summary of decisions made, and information on the number of licences in the Board's area. This requirement first applied for the 2017–8 financial year.²⁸</p>
Ability to address alcohol availability in specific localities deemed to be excessive	<p>Existing licences cannot be revoked to address availability. Cumulative impact assessments (CIAs) are an optional tool for licensing authorities to limit the growth of new licensed premises (both on and off-licences) in an area where there is evidence to show the type or number of premises is having a cumulative impact and undermining the licensing objectives. Responsible authorities (RAs) can still make an objection on the grounds of negative cumulative impact on one or more of the licensing objectives without a CIA being in place. The onus is on the RA to provide relevant evidence of cumulative impact. Cumulative impact policies (CIPs) were referred to in previous section 182 guidance but were not included within the 2003 Act. 'Cumulative impact assessments' (CIAs) were introduced in the 2003 Act by the Policing and Crime Act 2017, with effect from 6 April 2018. By now most, if not all, CIPs will have been reviewed and replaced with CIAs.</p>	<p>Existing licences cannot be revoked with the aim of reducing availability. Overprovision policies form part of the SLP for each area. Licensing Boards are mandated to identify localities within the Board's area, deemed to be 'overprovided' by specific types of alcohol outlet. In coming to a view on overprovision, the Licensing Board must consult local stakeholders, and must have regard to the number and capacity of licensed premises in the locality and any other matters as the Board thinks fit, including, the licensed hours of premises in the locality.^{24,28} The policy has to be evidence-based, informed by data on specific health, crime or other alcohol-related harms in the locality. Where an application is made for a licence that goes against an overprovision policy, there is a presumption that it will be refused unless the applicant can demonstrate sufficient relevant considerations to outweigh the policy in that specific case, having regard to the licensing objectives.</p>
Local policy options targeting temporal availability	<p>No national statutory restrictions: licensing committees set hours of sale. A minority of off-sales licences cover a 24-hour period; and most cities will also have 24-hour licences for a small number of on-trade venues.</p>	<p>For on-premises sales, the law includes a presumption against 24-hour licensing except in 'exceptional circumstances'. Alcohol cannot be sold for 'off-premises' consumption (i.e. to take away) outside the hours of 10.00 and 22.00.</p>

TABLE 1 Comparison of alcohol licensing systems and structures in England and Scotland (continued)

Issue	England	Scotland
	<p>The law allows for two other discretionary local policy options that have varying degrees of implementation.²⁵</p> <p>The late night levy (LNL) enables licensing authorities to raise a contribution from late-opening alcohol suppliers towards the costs of policing the night-time economy. It is a local, discretionary power but, if introduced, it must currently cover the whole of the licensing authority's area. The licensing authority will also choose the period during which the levy applies every night, between midnight and 6 a.m., and decide what exemptions and reductions should apply from a list set out in regulations. Only 10 licensing authorities in England currently operate a LNL, while two others operated a LNL but subsequently ceased implementation.³³</p> <p>'Section 142 and Schedule 18 of the Policing and Crime Act 2017 would reform the levy by: allowing licensing authorities to target specific geographical locations; extending the levy to include late night refreshment outlets; enabling Police and Crime Commissioners to request the licensing authority to propose introducing a levy; and requiring licensing authorities to publish information about how funds raised by the levy are spent. Section 142 and Schedule 18 are not yet in force at March 2022.'³⁴</p> <p>An Early Morning Alcohol Restriction Order (EMRO) is intended to enable licensing authorities to restrict sales of alcohol in the whole or a part of their areas for any specified period between 12 midnight and 6 a.m., if they consider this appropriate for the promotion of the licensing objectives. No exemptions are permitted to EMROs for particular premises, unlike the LNL. No EMROs are currently in operation.</p>	<p>In the Statement of Licensing Policy, Licensing Boards set local policy on hours of sale for different types of premises. Where an application is made against policy, seeking longer hours, there is a presumption the extra hours will be refused unless the applicant can demonstrate sufficient relevant considerations to outweigh the policy in that specific case, having regard to the licensing objectives.</p> <p>A change in local policy on hours of sale, that restricts hours of operation, cannot be used to take away hours from premises who are already licensed for such hours. The 2005 Act also contains specific conditions of a licence which must be applied for late opening premises.²⁴ These can be supplemented by further conditions imposed by a Board.</p>
Licensing of one-off events.	<p>Temporary Event Notices can be applied for to sell alcohol at an otherwise unlicensed venue (or at a licensed venue but outside the licence parameters, e.g. to extend opening hours). The Licensing Authority <u>cannot refuse</u> a notice unless the police or environmental health object to it (public health teams do not have the right to object). They must do this within 3 working days of receiving it on grounds that the event would contravene the licensing objectives. If there's an objection, a meeting of the licensing committee (a 'hearing') will be held at which the application can be approved, rejected or accepted with conditions added.</p>	<p>As explained in City of Glasgow Licensing Board,³⁵ an Occasional Licence allows alcohol to be sold on unlicensed premises for a specified period. Applications are sent to Police Scotland and the local Licensing Standards Officer for review who both have 21 days to respond to the Licensing Board. Details of the application may also be published online for a period of 7 days during which time any person may object to the Licensing Board. Police Scotland can issue a notice that to grant the licence would be contrary to the licensing objective to 'reduce crime and disorder'. If no Police notice, Licensing Standards Officer report or other objection is received by the Licensing Board, they must grant the application. Once the objection period has ended, the Licensing Clerk will consider the application and any reports received, before deciding whether to grant, amend or refuse the application. If the Clerk cannot determine the application, or if an objection or representation has been received, it will be referred for consideration at a meeting of the Licensing Board.</p> <p>Temporary extensions to the opening hours of an existing premises licence (e.g. beyond the current licensed hours) are handled as a licence variation application. Permanent changes to hours would be considered a major variation and put to the Licensing Board.</p>

continued

TABLE 1 Comparison of alcohol licensing systems and structures in England and Scotland (*continued*)

Issue	England	Scotland
Public involvement	Members of the public (e.g. residents, local councillors, or community groups) can attend and make representation at Licensing Committee meetings. Residents can also make representation on proposed EMROs. The Local Authority (local government) must consult with persons/bodies representative of businesses and residents in its area when reviewing their SLPs. 'Encouraging greater community involvement in licensing decisions and giving local residents the opportunity to have their say regarding licensing decisions that may affect them' is a key principle that should be considered by licensing authorities.	Members of the public can attend and make representation to or at Licensing Board meetings. Licensing Boards must consult the public when reviewing their SLPs. Each Licensing Board should also establish a local 'Licensing Forum' to ensure that community stakeholders have an active voice in scrutinising the operation of licensing in their area. The Forum's role is to give advice and make recommendations to the Licensing Board. Forums are made up of 5–21 members including at least 1 licensing standards officer, a representative from the health board, and commonly also licence holders, police, education, social work representatives, young people, local residents and members of the licensing board.

Objectives

In this new era of alcohol licensing, decisions to grant, amend or refuse licence applications are guided by statutory 'licensing objectives' in both systems. In Scotland, these objectives are preventing crime and disorder, promoting public safety, preventing public nuisance, protecting children and young people from harm, and protecting and improving public health. England's objectives are similar except that there is no objective focused on public health. The public health objective in Scotland was included in the recommendations of the Nicholson committee 'Review of Liquor Licensing Law in Scotland' in 2003 without giving a detailed rationale, simply stating that they felt it was as important as any of the others.³⁶

Health involvement and structures

In Scotland, local health boards – administrative authorities ($n = 14$) responsible for running the NHS locally – became 'statutory consultees' (SCs) in 2011²⁷ (see [Table 1](#)). These 14 health boards are consultees to 40 local Licensing Boards. In England, Directors of Public Health (DPH) ($n = \sim 155$) were included as 'responsible authorities' (RAs) in 2012 giving them a similar statutory role in working with approximately 350 licensing authorities (see [Table 1](#)). In Scotland, health input to licensing is largely NHS-led, involving staff within NHS PHTs departments, NHS health improvement departments, Health and Social Care Partnerships (which are joint NHS-local government bodies), or Alcohol and Drug Partnerships (multiagency bodies which can be NHS or local government-based). Scottish health actors are supported by Alcohol Focus Scotland (AFS), a national charity established in the 1970s which is focused on preventing and reducing alcohol harm. In England, responsibility for local public health matters (including health input to licensing) moved to local government in 2013 where it is led by DPHs and supported by public health professionals.³⁷ Some PHTs in England, therefore, work directly alongside licensing teams in local government. From 2014 up to 2021, English PHTs were supported on licensing matters by Public Health England (PHE), a national body created in 2013;¹⁷ the relevant PHE team has now moved to the UK Department of Health and Social Care as part of the 'Office for Health Improvement and Disparities'.

In this paper, we use the term 'PHT' to describe practitioners or teams who have a primary remit in relation to health or alcohol, who engage with local alcohol premises licensing with the aim of reducing alcohol-related harms, even if titled/situated differently in the two nations as described above.

Local licensing policies

Statements of Licensing Policy (SLP) must be produced by local licensing authorities and renewed at least every 5 years, in both England and Scotland. The timing of renewal of SLPs in Scotland is set nationally, so all local areas review and revise their policies at the same time (within 18 months of local government elections). Previously, in Scotland, the renewal interval was every 3 years, so SLPs in Scotland cover the periods 2007–10, 2010–3, 2013–7 and 2017–22 for all areas. In contrast, the timetable for SLP renewals in England is unique to each area, depending on when the policy was previously revised. The content of these policies varies between local areas, but some of the policy options available also vary by nation. The importance of the local SLP in justifying decisions to decline licences (and the importance of the provision of a clear statement of reasons if doing so) has been reinforced by a legal case in Scotland.³⁸ The importance of policy is underlined by the fact that appeals to licensing decisions made on the basis of SLPs in Scotland have usually targeted procedural defects in the preparation of the policy, as otherwise applicants would need to demonstrate why the policy should not be followed or why their premises would have minimal impact on health, both difficult to do.^{39,40}

In Scotland, SLPs must include a statement as to the extent to which the Licensing Board considers there to be overprovision of licensed premises or licensed premises of a particular description in any locality within the Board's area (see definition in [Table 1](#)). This may include a determination that the whole of the Board's area is overprovided and must be based on data. In practice, the required data relating to the health objective come from PHTs. In England, there is no requirement for Licensing Authorities to assess or report on overprovision in developing their SLPs. However, Licensing Authorities do have discretionary powers, following consultation, to introduce cumulative impact assessments (CIAs). CIAs replaced Cumulative Impact Policies (CIPs), which were similar but were in guidance only and did not have a statutory basis.⁴¹ CIPs were found to vary greatly amongst those local authorities¹² that had introduced them but bear some similarity to overprovision statements. They typically involve identifying one or more subareas within the jurisdiction of the Licensing Authority, referred to as cumulative impact zones (CIZs), where the density of alcohol outlets is considered to be adversely impacting on the licensing objectives. Within both CIZs and overprovision areas, licence applicants need to demonstrate that the granting of the application will not undermine the licensing objectives, thus reversing the usual burden of proof. The extent to which CIAs represent a genuine increase in powers to reject licences has been a matter of legal dispute. Applicants who clearly state how their operating schedule and good management will ensure that the licensing objectives will not be undermined if their application is granted may well have their application approved on appeal if not by the committee.

The implementation of overprovision policies to refuse licence applications in Scotland has been subject to several legal challenges. These cases have primarily centred on the process by which overprovision policies were put in place (procedural matters such as failure to properly consult; failure to set out proposals on which consultation was based or failure to consider other relevant policies), rather than challenging the principle that a licence may be rejected on grounds of overprovision where a policy is in place. Each of the judgements has arguably helped to clarify or confirm aspects of the overprovision policy process, but there is some indication that the cases have also had an impact on Licensing Boards' confidence to refuse licence applications on the basis of overprovision.^{18,42} The overprovision cases in Scotland have also informed developments in the collection and presentation of local health data to help construct the case for these policies.

In England there are two further discretionary policy options: late night levies (LNLs) and Early Morning Alcohol Restriction Orders (EMROs) (see [Table 1](#)). However, few local authorities have implemented LNLs and none have implemented EMROs after alcohol trade bodies mounted a concerted campaign of legal challenge following the introduction of EMROs in two areas (Hartlepool and Blackpool) in 2013.^{43,44}

Methods

This paper reports novel qualitative data seeking to explain quantitative findings from the larger ExLEnS study described above. The interviews analysed in greater depth for this paper were with individuals sampled from the 39 PHTs who took part in the overall study. We, therefore, firstly describe how these 39 PHTs were sampled and recruited for the overall study, and then outline how and with whom the interviews were conducted.

Public health team sampling and recruitment procedures

In accordance with our protocol,²¹ we purposively sampled 20 PHTs (14 in England and 6 in Scotland) who had been actively engaging with local alcohol premises licensing in recent years. Recruitment took place in 2017–9. All PHTs in England and Scotland were informed about the study by e-mail and invited to express interest. Calls with interested PHTs scoped out their level of engagement in licensing, and this information was used along with advice from AFS and PHE, published reports and case studies to select and recruit 20 active PHTs purposively varied in terms of region and rurality. These 20 ‘higher activity’ areas were matched to 20 others with less active PHTs using propensity score matching (England) or cumulative root mean square error (Scotland). One recruited ‘lower activity’ area did not participate in data collection giving a final sample of 39 areas.

All teams and individuals (see below for sampling of individuals) were provided with an information sheet and had the opportunity to discuss the study with the team, prior to consenting to take part in structured interviews. A consent form was completed on behalf of each PHT by the lead professional, usually the Director of Public Health. Individuals participating in in-depth interviews received a separate information sheet about participation and completed separate written consent forms.

The profile of participating areas is summarised in [Table 2](#). A detailed breakdown has been published elsewhere.²²

TABLE 2 Profile of participating areas

England (n = 27)	Scotland (n = 12)
London and South East (11) North West (6) North East and Yorkshire (4) South West (3) East (3)	West (6) East (4) Northeast (2)
<u>Type of Local Authority</u> Unitary authorities: 13 Lower tier authorities: 14	Type of local authority is not applicable in Scotland.
<u>Urban–Rural Classification</u> 1 (most rural): 1 2: 2 3: 5 4: 13 5: 0 6: 6	Urban–rural classification is not provided for Scotland as it would be likely to identify the participating areas.

Data collection and sampling of interviewees

Two sets of interviews were conducted for the study.

Firstly, all available representatives of each PHT with experience of licensing activity in the time frame of interest (1 April 2012 to 31 March 2019) took part in one or more largely *structured* face-to-face or telephone interviews (total $n = 66$) in 2018 and 2019. The interviews focused on *describing* PHT activity in engaging with alcohol premises licensing, but interviewees also spontaneously gave *explanations* for their activity in many of these interviews. The primary purpose of these interviews (along with separate documentation analysis, not reported here) was to provide data to develop and apply the PHIAL measure as described in the section [Background](#).²² The PHIAL measure was then used to quantify and compare the intensity and nature of public health activity across 19 activity types in 6 overarching categories ([Table 3](#)) and reported earlier²² and above. For the current paper, the explanations given by interviewees were analysed qualitatively (alongside additional in-depth interviews, see below) to help explain differences in activity types and levels between Scotland and England over time identified using the PHIAL. Structured interviews lasted between 8 and 212 minutes (median length: 52 minutes) and were audio-recorded with participant permission. Structured interviews were conducted by co-authors Mohan, Maani, Purves and Fitzgerald.

TABLE 3 Categories of PHT activity to influence alcohol licensing

Broad category	Description
1. Staffing for PHT activity to influence local alcohol licensing	Staffing for PHT activity to influence local alcohol licensing.
2. Reviewing alcohol licensing applications	Engaging in an activity or process to decide whether to take action in relation to individual alcohol licensing applications.
3. Influencing and responding to individual licence applications	Engaging in any activity to influence the submission, type, content or outcome of alcohol licensing applications (excluding that covered elsewhere).
4. Using Routine or Bespoke Data on Alcohol Licensing and Alcohol-Related Harms	Collection, collation, analysis, or other use of data to inform, or use in support of, PHT activity to influence local alcohol licensing.
5. Influencing local stakeholders or licensing policy	Any activity to influence licensing policy or people, or work with other stakeholders (other than the public).
6. Engagement or involvement of the public	Any activity to engage or involve the public in relation to alcohol licensing including the use of media.

Secondly, in all 20 higher activity areas, those members of PHTs who had experience of engaging in licensing took part in *in-depth* one-to-one interviews ($n = 28$) focused on why they engaged in licensing in the ways that they did. Members from lower-activity PHTs were not included in in-depth interviews as their lower levels of involvement and experience in licensing meant that they had less to reflect on, and they generally explained their lower level of involvement during the structured interviews. Sampling of individuals focused on ensuring that at least one interview was conducted in all 20 recruited higher activity areas, in accordance with our protocol²¹ and was purposive to optimise diversity in terms of the remit and role of the interviewee. The final sample is outlined in [Table 4](#). These interviews lasted between 36 and 156 minutes (median: 73 minutes) and were audio-recorded with participant permission. Conducted by co-authors O'Donnell, Mohan, Maani and Purves, the interviews included a focus on interviewee roles, responsibilities, approaches and purpose in the licensing system, amongst other topics not reported here.

TABLE 4 Breakdown of in-depth interviewee sample (total $n = 28$)

Location	Scotland ($n = 9$); England ($n = 19$)
Gender	Female ($n = 18$); male ($n = 10$)
Role	England: public health team member ($n = 9$); Director or Assistant Director of Public Health ($n = 4$); Specific alcohol/substance misuse remit ($n = 5$); other public health ($n = 1$) Scotland: NHS public health consultant/health improvement ($n = 6$); alcohol and drug partnership ($n = 3$)

Data management and analysis

Analysis of the two interview data sets was conducted in parallel using a similar process for the purpose of this paper. With participant permission, interview recordings were professionally transcribed and then anonymised and imported into NVivo 12 for analysis. Co-authors Mohan, Maani, Purves and O'Donnell coded transcripts against a set of activity and thematic categories created using deductive (reviewing research questions) and inductive approaches (reading transcripts). These categories were developed iteratively, with ongoing refinements made on the basis of re-examining data and reflexive team discussions. After initial coding, explanatory text relating to the seven key differences outlined above were identified, reviewed in detail by co-authors Mohan and O'Donnell in discussion with Fitzgerald. Original transcripts were revisited as needed to add context and depth. Co-author Mohan wrote up interim findings, which were reviewed and revised by Fitzgerald with input from Mohan, O'Donnell, Egan and Purves (who had all read transcripts/conducted interviews/both) and with input from other co-authors, some of whom were members of the ExILEnS study steering committee (co-authors Mahon, Smolar, Briton and Fraser).

Ethical approval and public involvement

The study was approved by the University of Stirling Ethics Committee for NHS, Invasive or Clinical Research (NICR 16/17 – 64 and NICR 16/17 – 064A) and the London School of Hygiene and Tropical Medicine Observational/Interventions Research Ethics Committee (14283). NHS Research and Development approval was secured from all NHS Boards for participating PHTs in Scotland. This was not required for PHTs in England, which are based within local government.

The Study Steering Committee included representation from two members of the public, who were invited to provide feedback on the overall design of the study, study materials, and early findings to inform data collection and interpretation.

Findings

Participants described in detail how they and their colleagues had sought to influence alcohol licensing from 2012 to 2019, and the rationale for the approaches taken. Further detail and available explanatory data, relating to the seven identified differences in activity between English and Scottish PHTs, are outlined below.

1. Earlier initiation of PHT involvement in alcohol licensing in Scotland

Scottish PHTs more often described their involvement in alcohol licensing arising from early in the study period, often as early as 2012, or in some cases earlier. Three potential reasons for this emerged from the data: prior work preceding when Scottish health boards were made SCs in 2011; input to SLPs which became due for renewal in all Scottish Licensing Boards in 2013 (though a few PHTs inputted to SLPs in 2009); and support activity from AFS. Activity levels in English PHTs increased in 2014, most likely due to support activity from PHE.

Firstly, in Scotland, some public health actors had been involved in health input to licensing even prior to the point at which health was made a SC.

He [an Alcohol and Drug Partnership (ADP) colleague] had been here twelve years ... would have been involved in writing the ADP strategy and this is where you see the first mentioning of alcohol licensing for us as an ADP. There is a wee bit of mention about the Licensing Forum in the involvement in licensing here ... [shows local ADP strategy document for 2009-2019] ... so licensing was already a priority for the ADP in 2009.

(PHT, Area 32, Scotland)

Secondly, the timing of the issuing of SLP was a reason for PHT activity in Scotland occurring as early as 2012 – because each licensing board in Scotland had to review their SLP by 2013, consultation and development work started in 2012. Scottish PHTs were often actively involved in supporting this process through provision of data and analysis, or were involved in responding to or facilitating public consultations around draft revised SLPs. Thus, there was increased relevant activity for most PHTs in the year or months leading up to the publishing of SLPs.

... from the start [2013], I have also been heavily involved in producing data to support the development of policy.

(PHT, Area 37, Scotland)

Thirdly, the early involvement of Scottish PHTs in licensing may reflect the timing of support activity by AFS who produced a widely disseminated report in 2011 called 'Rethinking Alcohol Licensing' (MacNaughton and Gillan, 2011), followed by regional events for public health and licensing practitioners.¹⁰ AFS also organised an annual National Licensing Conference which first included health stakeholders in September 2011.^{15,45}

AFS had, they had a specific day where they brought people from licensing across Scotland together, to shape our response to the new national guidance that comes out to licensing boards in Scotland ... that was a really good practice because it was a full on day where everybody got to contribute ... I think that really strengthened all of our approaches.

(PHT, Area 35, Scotland)

2. Step-change increase in activity in England from 2014

In contrast, participating PHTs in England were generally slower to get actively involved in engaging with alcohol premises licensing and were only designated as Responsible Authorities in 2012. This explains

some of the lower activity in the early years of our data collection period. The distinct rise in activity levels identified from 2014 onwards appears likely to be attributable to national and regional support activities, and to the participation by two PHTs in a Home Office initiative known as 'local alcohol action areas' (LAAAs).

The year 2014 was the start of a 'big push' from PHE national and regional teams around getting local PHTs engaged in licensing that included training sessions, briefing notes, case studies and a national 'Licensing and Public Health' network.⁴⁶ Around the same time, regional bodies such as Balance Northeast, DrinkWise and Safe Sociable London partnership, alongside the Local Government Association, were also proactively supporting English PHTs on licensing matters.^{47,48} One PHT described a learning phase as they started to work on this agenda and the contribution of PHE to the feeling that they could 'do more' (PHT in London/South East) on this – in this area they brought in a regular process of reviewing licence applications towards the end of 2014.

The UK Home Office's LAAA programme was set up in England/Wales to tackle alcohol harms,^{49,50} and was launched in February 2014 in 20 areas. Two of the 20 participated in this study, though 7 other of our study areas took part in a second phase from January 2017. LAAAs required local licensing authorities, health bodies, the police, businesses and other organisations to work together, with the key aim of 'reducing alcohol-related crime and disorder, and reducing the negative health impacts caused by alcohol', underpinned by a 'goal of promoting diverse and vibrant night-time economies'.⁴⁹ One area describes how their participation in the LAAA enabled them to make progress on data collection around licensed premises sales of alcohol, and in developing their SLP.

... this [mapping licensed premises] is generally done once a year. It has proven quite difficult ... it was a lot easier in 2014 because basically we said 'government have introduced an initiative ... [PHT area] has been declared as a Local Alcohol Action Area. We're looking at trying to reduce alcohol related crime disorder and the impact that it has on our NHS, do you mind if I just have a look at the alcohol that you sell?' 'Yes' – it was fine, absolutely fine.

(PHT, Area 38, England)

3. More active efforts to input to local SLPs in Scotland

Public health teams in both England and Scotland described the importance of their work in inputting to SLPs. Many PHTs also saw this as an opportunity to maximise impact in the limited time and capacity they had to spend on responding to licensing applications. In England, some PHTs viewed their SLPs as the best way to influence conditions on new licences and in a few cases, occasional (temporary) licences. In Scotland, this was driven by a belief that their input to SLPs may be more important than making objections to licences, when seeking to address harms from alcohol. Attempts to object to individual premises/applications were limited by difficulties establishing a causal link between granting one specific licence application and adverse impact on the licensing objectives.¹⁸ It was felt easier to make the case at area level for policy.

I believe [influencing policy] to be the most important thing. I think what you do with your letters [of objection] along the way is tinkering around the edges. The most important thing is getting the policy right in the first place, because if the policy is right, the Board should be making the decisions with Public Health in the front of their mind anyway, so you shouldn't need to object, because the policy should be robust enough in terms of overprovision.

(PHT, Area 37, Scotland)

Scottish PHTs tended to be active from earlier in the period 2012 to 2019 as on this specific type of engagement, as well as having a higher level of activity on average throughout the period.²² All Scottish PHTs recruited as active areas consistently inputted to SLPs, whereas some PHTs in England did not engage with policy at all. Of those that did, input was sometimes fairly short-lived.

One reason for more sustained activity in Scotland is that SLPs were renewed at least twice (2013 and 2017) under regulations in Scotland, whereas there may have been only one review that fell into our time frame in many English PHTs. Secondly, Scottish areas were more likely to get involved in policy as they were more generally active at an earlier stage on licensing, as outlined above. Some of our PHTs in England reflected on the fact that it took them some time to realise the importance of the SLP in terms of potential public health impact – ‘it didn’t factor as being as significant as it could be’ (PHT, Area 27, England). So even when there were two SLPs renewals in an area our time frame of interest, the PHT may not have been involved in the first one.

Finally, it appears to be more common in Scottish PHTs for them to start work to prepare for the next round of review of the local SLP from well in advance – working with other agencies and licensing colleagues, and gathering diverse data to support the mandatory overprovision assessment to be included in Scottish SLPs.

4. Greater involvement of senior leaders in Scotland

Many senior public health staff in Scotland were active in reviewing applications, giving presentations to the Licensing Board, signing off on applicant letters and engaging in consultations for the development of SLPs. In England too, DPHs were often ‘the one who has gone to the Licensing Committee and presented our cases’ (PHT, Area 16, England).

Greater involvement of senior leadership in Scotland compared to England appear to reflect the volume and diversity of senior staff involvement in Scotland, rather than lower DPH activity in England compared to Scotland. In England, PHTs were based in local government, often alongside the licensing team, whereas in Scotland health input to licensing was external to the licensing team and involved input from diverse organisations. Thus, a single Licensing Board in Scotland might have health input from the local NHS Board and its DPH, as well as from the local Health and Social Care partnership, and a senior professional there and/or potentially from a senior colleague acting for the ADP.

... there was some strong feelings in the Public Health Department [the NHS department that covered multiple licensing board areas] that really it should be the Director of Public Health that should sign off [letters of representation or objections]. So, for some of the other areas that maybe [this DPH] was involved in, she would act as a guide almost, sort of give some advice and guidance in terms of where ... they feel that Public Health would put an objection in and that letter would then be signed off by the Director [of Public Health].

(PHT, Area 31, Scotland)

5. Greater diversity of activity around responding to licence applications in England

In both nations, there was a statutory requirement that licensing teams notify PHTs about applications for new premises licences or major variations to existing licences. Most of the more active PHTs in both nations had established routine processes for logging, monitoring and reviewing these applications. These processes helped PHTs to decide whether or not and how to respond to applications. Decisions on how to respond to applications were weighed up differently by PHTs in both nations, explained in part by the structure of the systems in place, and the philosophy of the PHTs.

In England, most PHTs chose to negotiate with applicants or their solicitors rather than have applications proceed to being considered at a licensing committee meeting, and in a few cases, made themselves available to work with potential applicants before they even submitted an application. There were two main reasons why several English PHTs used this approach. First, PHTs considered attending committee meetings to be time-consuming and resource-intensive for them and for applicants, creating an incentive to avoid them. If they or other RA did not lodge a representation/objection for new licenses or major variations, no committee meeting was required as the licence would be automatically

granted. Many applicants reportedly preferred engaging with PHTs to come to an agreement about licensing conditions on their applications, to avoid an objection from public health and therefore a committee meeting. Second, there was no guarantee that a PHT's representation would be successful at a committee meeting and many PHTs reported feeling low in confidence about attending a committee meeting due to their lack of experience, or not having strong enough evidence to support their representation. Thus, most English PHTs found they were more likely to be successful in influencing licensing conditions on individual applications rather than objecting to applications.

I kind of see it as a bit of a failure if we end up at a hearing because that means that we've not been able to reach a decent compromise, we haven't been able to communicate decently ... I've withdrawn several reps because I've got what I've requested or a version of what I've requested that I believe to be fair enough ... prework is probably more important than getting people to hearings. [A hearing is] very costly for everybody involved and doesn't necessarily end the way we want it to either.

(PHT, Area 30, England)

as soon as there's a whiff of a hearing then your ability to have a constructive relationship with the premises is gone really because suddenly you are in a very confrontational situation. Whereas if you can do it on the basis that 'we could take you to a hearing but we want to help you not go there' then they realise you're kind of on their side and will work with you.

(PHT, Area 24, England)

In Scotland, there was less incentive for PHTs or applicants to make a deal to avoid a Licensing Board meeting, as such meetings went ahead regardless of whether the PHT made a representation or objection; however, applicants could avoid attending a meeting if their application was unopposed (see below). More salient though were Scottish PHTs' strong objections to engaging with applicants or their representatives directly outside of Licensing Board meetings on grounds of a perceived conflict of interests between industry actors and public health actors. If PHTs had queries about an application, they preferred to seek answers via the local licensing team.

... from my point of view, it's not that we haven't bothered to [engage with applicants], I would have it as a policy that we don't engage with the applicant directly. I think that is too controversial and that it opens it up to a more personal interaction [with industry] whereas I would, if I were to have any questions I would direct them to the Licensing Board.

(PHT, Area 32, Scotland)

Other Scottish PHTs viewed formally submitting representations to the Licensing Board as the only way of ensuring that applicants would adhere to any conditions requested. This view was borne out of past experiences, with one PHT, for example, noting:

I think our fear is, that verbal approach does not necessarily mean [a condition on a licence] will be adopted. So we would like to see something formal, to know that there is no opportunity for them to wiggle out. Because sometimes, just even at a Licensing Board, somebody saying verbally 'I agree, I will not stock high end alcohol products' and the Board say 'oh that is really commendable, well done'. If it's not a condition, they do not need to abide by it. So we've been caught like that before.

(PHT, Area 32, Scotland)

However, when interviewed again 8 months later, they reported some changes to their approach, in that the licensing team would negotiate with applicants or their solicitors prior to licensing board meetings if there were minor changes that the PHT wanted applicants to make. If applicants agreed and these changes were confirmed before the Licensing Board meeting, the PHT would then withdraw their representation or objection – similar to the practice that was more common in England except that the negotiation was not done directly by the PHT. This change was instigated by the local area Licensing Board, in a bid to simplify the application process and reduce costs for applicants. This new way of

working was welcomed by the PHT, who noted the process had been ‘evolving in a good way’ (PHT, Area 32, Scotland).

6. Scottish PHTs were more commonly involved in making or leading representations or objections to licence applications

The presence of the public health objective in Scotland appeared to give more confidence to Scottish PHTs about submitting representations independently of other Statutory Consultees. In England, some PHTs felt that they needed to work with the police or other Responsible Authorities because they perceived public health data were not taken seriously, or that it did not always fit exactly under the four other licensing objectives, so they were more likely to support representations or objections made by others, including ‘the police, the licensing authority or others – we’ve found it helps to influence the outcome more’ (PHT, North of England).

Finally, some Scottish PHTs held a belief that they could not collaborate with the police when deciding whether or not to object to an application, because that would constitute a form of ‘collusion’, not permitted by law. Though this was a misperception arising from a requirement in criminal law for witnesses not to collaborate, which does not have any legal parallel in licensing, it arose as a key reason why some Scottish PHTs worked on representations independently of other SCs. This fear about the legality of working together also extended to data sharing in relation to overprovision assessments in at least one case.

We wouldn’t be able to put something [a joint response to an application with other SCs] in. I believe that would be, I’m trying to think of the way the Act is worded. It’s something, it is worded about, I’m sure the word collusion is used there. So, I think it would be absolutely fine for us to talk to one another and share views and opinions. I don’t think, there would never be a time where you would put in a joint response.

(PHT, Area 31, Scotland)

In contrast, many English PHTs consulted with other RAs about the approach they were going to take regarding an application, with some even sharing information and data so that they could submit the same representation/objection:

... we’ve got that team approach of all the Responsible Authorities working together. And what we do is that we pool our information. So, we receive an application, and we share our views on what we think the approach should be to deal with that application, and then we look at how we can gather the evidence together that we’ve got within individual service areas and organisations, to support us taking any action. And then we’ll do a review of what we think the best action is for us to take ... that is how we maximise the achievement of the licensing objectives ... present a united front when meeting with applicants, that we are consistent in our views in what we’re saying to applicants ...

(PHT, Area 38, England)

7. Scottish PHTs more commonly sought to involve the public in alcohol licensing

All six active PHTs in Scotland sought to involve the public in licensing either occasionally or consistently throughout the period 2012–9, whereas just 3 of the 14 such areas in England did so. This can be explained in part by the existence of local Licensing Forums in Scotland (see [Table 1](#)), on which members of the local community and specifically local young people can sit. These Forums were routinely attended by PHTs and sometimes PHTs took a more active role – organising or chairing the Forum on behalf of the Licensing Board.

I tend to lead the licensing forum, even though I’m not in the position of Chair ... I do quite a bit of feedback nationally and locally, bringing in some of the national data ... and evaluation that’s been done [and] giving them an update on the alcohol profile. But I work very closely with whoever’s in the Chair

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position on the licensing forum, I'll sit down with them, we'll create the agenda together so I do tend to be a bit of the driving force for the forum and, I think that otherwise that may have crumbled, as I think has happened in other areas where the forums are not as strong.

[PHT, Area 34, Scotland]

Over and above this, some areas used time-limited funding to boost their engagement with local communities, perhaps because this issue had started to receive attention in reports and events in the sector.^{51,52}

... we had an ADP underspend in 2015 and we employed a Health Improvement Practitioner for a year to come in and look at community response to licensing ... I got him to do some awareness raising ... and got some, an understanding, some training opportunities and understanding about how they [the local community] could basically react if, should an application come up in their area.

(PHT, Area 31, Scotland)

This more intense public involvement was rarely sustained, due to time constraints and limited capacity and resources; however, some PHTs had established links to community groups and were invited along to group meetings. They used these links to provide education about alcohol harms and alcohol licensing, or raise awareness of the SLP, often using the AFS toolkit to do so.

[Colleague] actually attends the meetings [of a local community group], but I got in touch with them to say 'there is an application for a premises in your area, if [you] want to make a comment', because they would not be notified [of the application otherwise] ... Because we have such a big alcohol problem in [that area].

(PHT, Area 32, Scotland)

One PHT who worked closely with their local Licensing Team was approached by a group who identified drugs and alcohol as an area of concern for their community:

... I steered them [community group] towards licensing, because of their involvement in the community and just because people don't automatically think about the impact that licensing can have. They found that really helpful ... They agreed that actually, they would want to be more involved and understand licensing a bit better and then going forward, be able to put in representations, if there was something happening in their community ... we'll also use Alcohol Focus Scotland's toolkit for community members.

(PHT, Area 34, Scotland)

When the time came to review the local SLP, Licensing Boards/Committees are required to consult the public. Some PHTs got involved in supporting these consultations, whereas others preferred to engage through existing mechanisms for community engagement such as Community Councils or the Licensing Forums.

In England, just a few PHTs proactively involved the public specifically on licensing matters. Others described interacting with the public more generally on alcohol matters, such as to inform an alcohol 'Inquiry' or alcohol strategy for the local area, but alcohol licensing was not raised as a major focus of such discussions.

It is something we have been considering, but we haven't done anything directly with the public from a Public Health perspective. We have consultation engagement with public and wider stakeholders from the perspective of developing the alcohol strategy in the past and moving forward with the new one, but licensing is only a small part of it and I think it probably, to be honest, gets missed in terms of discussion.

(PHT, Area 16, England)

One English PHT who, through conducting the alcohol enquiry for their area, recognised the need for the public to be trained on alcohol licensing, and decided to develop a toolkit which was informed by the one developed by AFS for this purpose:

... this was more asking them what they think the issues are around alcohol and one of their recommendations was to do with a toolkit about licensing which is why we're now doing the toolkit.
(PHT, Area 27, England)

Discussion

This paper explores in-depth differences in the timing and nature of PHT practice between Scotland and England and what factors might explain such differences. Differences in the timing of legislative changes, giving public health a statutory role, may have led to earlier involvement of PHTs in Scotland, but the role of AFS in raising the profile of licensing as an issue for public health at that time was also important. The timing of an increase in activity on licensing by English PHTs could also be traced to national support, in this case, from PHE, working alongside or together with local groups such as Balance North East, DrinkWise NorthWest and the Safer Sociable London Partnership, as well as the Local Government Association. AFS support is likely also to explain greater involvement of PHTs in Scotland in working with communities on licensing. This is the first study to find evidence of the importance and impact of AFS and PHE support in generating PHT engagement on licensing matters. Our previous work showed that there was also some reduction of PHT activity in England in 2017–9, which was not the case in Scotland, coinciding with a time of a lower national profile for this work from PHE.²²

Legal differences in the timing of renewal of SLP, with them occurring more frequently in Scotland during our data collection period (2012–9) and at the same time for all Licensing Boards, may have provided more opportunities for Scottish PHTs to influence policy and a clear timetable/impetus for organisations providing them with strategic support. The structure of local public health bodies in Scotland also meant that there were often more people, organisations and more complex arrangements and relationships amongst those seeking to support a public health perspective in the local alcohol premises licensing regime. This may also have helped to ensure a higher level of public health activity on licensing issues in Scotland than in England.

Previous studies have discussed the use of the public health objective for licensing in Scotland,⁹ and limitations on PHT engagement that might arise as a result of its lack in England.^{16,17} The legitimacy given to public health through this objective may have partly explained why PHTs in Scotland were more active in making representations or objections to licence applications without needing to involve other statutory stakeholders such as the police. Similarly, the lack of a public health (PH) objective may have made English PHTs less confident about doing so and nudged them more towards negotiating conditions on licences with applicants rather than objecting outright. We discuss the potential value of a public health objective in detail separately;⁵³ however, our findings suggest that the public health objective does not fully explain the differences in practice observed, and that previously little discussed legal and structural factors may also be important. For example, we identified a surprising (mistaken) belief amongst some experienced PHT colleagues in Scotland, that working with other Statutory Consultees to share data and co-ordinate a joint response to a licence application would constitute illegal ‘collusion’. There is no basis for this belief in civil licensing law, and it suggests a need for clear guidance to be issued, perhaps by licensing teams or AFS.

Public health teams in England were more likely than their counterparts in Scotland to negotiate with applicants or their solicitors to avoid new licence applications having to go to a licensing committee ‘hearing’. By avoiding having to attend a hearing, this put less strain on PHTs in terms of time and resources available for alcohol licensing. This practice in England has been found previously,¹³ but this is the first study highlighting that this incentive to avoid a meeting does not exist in the same way in Scotland. All new licence applications are considered at Licensing Board meetings in Scotland, and this is one reason why Scottish PHTs did not tend to negotiate on applications. Another is that Scottish PHTs did not feel it was appropriate for them to liaise directly with licence applicants; they seemed to be more sensitive to likely conflicting interests between public health and licence applicants. This may reflect the national alcohol policy context in Scotland which takes a strong public health approach⁵⁴ Thirdly, PHTs in Scotland tended to be focused mainly on containing availability by avoiding new premises opening, rather than shaping how premises operated¹¹ and so negotiation does not make the same sense in this context. An emphasis on responsible retailing is a more traditional focus of licensing,⁴³ and may

have been more common amongst PHTs in England at least partly because they are based within local government, and often working directly alongside the licensing team.¹¹

These findings demonstrate that relatively minor features of the workings of a licensing system may have important implications for how it operates in practice and in particular for opportunities for public health influence. Public health involvement in alcohol licensing systems is underexplored internationally, though many Australian states and territories include 'harm minimisation' as an 'object' (or purpose) of liquor licensing.¹⁹ In a comparison of licensing systems between England and Australia, Foster et al. (2017) discuss the details of this harm minimisation requirement but make no reference to the involvement of PHTs in Australian licensing.⁵⁵ Licensing legislation in Ireland gives a role for the Health Service Executive (which runs publicly funded health services there),⁵⁶ but we could not identify any research exploring how this role is fulfilled.

The importance of differences, in public health approaches in terms of reducing harm, is largely unknown. The quantitative analyses in the ExLlEnS study found no association between the extent of PHT efforts (measured over 7 years) and health and crime outcomes.⁵⁷ Qualitative data from the same study suggested that public health input was largely valued and was slowly reorienting the licensing system in some areas, especially in Scotland.^{58,59} It is likely that any public health impact is limited in its effects by limitations in the licensing system more generally, which cannot reduce availability or effectively address remote alcohol sales, though large-scale studies have found some effects.^{60,61} Either way, by engaging in licensing, PHTs can gather intelligence to better understand and communicate the limitations that exist from a public health perspective. In addition, the operation of the public health objective in Scotland relies on public health data and input.

Further research could helpfully focus on whether the differences in PHT practices identified make a difference to their success in influencing licensing policies and decisions and examine the impact of individual activities. The ways in which temporary increases in availability are handled by the two licensing systems remain underexplored and may be an important driver of additional availability.⁶² These include both one-off applications from unlicensed venues and requests for occasional expansions in opening hours from licensed venues. Recent changes in licensing legislation in Northern Ireland, permitting many more of the latter, highlight the importance of better understanding how public health and public health engagement in licensing may be affected. It would also be beneficial to better understand where the erroneous belief about collusion with other stakeholders came from in Scotland and how it may change practice once PHTs are aware that there is no legal barrier to full collaboration with the police. Finally, it would be helpful to understand more about the influence of support from national organisations in the two nations with differing constraints on resources and advocacy. This is of additional interest since PHE's team covering alcohol availability is now part of the Office for Health Improvement and Disparities, which is part of the Department of Health and Social Care in the UK Government, rather than an arms-length body.

Strengths and limitations

There are several key strengths to this qualitative strand of the ExLlEnS study. It is the first study to gather primary data on public health engagement in licensing from professionals across differing licensing regimes. The data set is large, based on 94 interviews with public health professionals and covers a large group of PHTs working in diverse communities. The differences in practice, discussed in the paper, were originally identified through the application of a detailed measure developed over several years by the ExLlEnS team. These differences and the development of the measure are reported separately,²² and this paper fills an important gap by exploring the differences in detail including potential factors which have led to them. Prior papers on public health practice have been focused on a single nation and have discussed the influence of the most obvious difference between the licensing systems in Scotland and England – the presence/absence of a public health objective. This paper goes

beyond that by outlining in detail other important legal and structural influences. Finally, this paper provides an authoritative and thorough guide to the similarities and differences between the two licensing systems and their implications for public health practice. As such we expect this paper to be of interest internationally to those considering the design and implementation of licensing regulations in similar permit-based systems worldwide.

The study also has several limitations. As with any interview study, our findings are limited by the ability of interviewees to recall their past activity or the influences on past decisions; however, our original activity measurements included documentation reviews and interviews with former PHT members. These safeguards were particularly important for considering the differences in timing of activity. Full limitations of the activity measurement are reported previously.²² We did not statistically analyse differences in practice between Scotland and England as the study was not designed to do so; thus we only explore differences here that are very clearly visible in the data reported previously (Figure 4 of Fitzgerald *et al.*²²). Some of the 19 types of PHT activity compared in the study cover more than one specific activity and we are unable to disaggregate these to compare practice at a more granular level. For example, we did not see any difference between the two nations in PHT activity around 'temporary increases in availability', even though on the surface the legal difference between a Temporary Event Notice (in England) and an Occasional Licence (in Scotland), including the ability of PHTs to object to the latter but not the former, seems important (see [Table 1](#)). This may have been because this category of PHT activity also included action on applications for temporary increases in hours for premises that were already licensed. While based on extensive interview data, the potential reasons for the differences in practice rely on the interpretations of our interviewees and our co-author team. Recognising this, we involved legal experts and colleagues from AFS and (formerly) PHE to ensure that we drew on extensive knowledge and experience in licensing in coming to our conclusions.

Conclusions

While the alcohol premises licensing systems in England and Scotland are similar on the surface, there are important differences between them that influence how PHTs seek to engage with licensing matters. These differences include, but also go beyond, the presence or absence of a public health objective in licensing legislation, and include procedures for handling applications, public health organisational arrangements, the timing of renewals of local SLP and the handling of licensing for one-off events. Our findings suggest that seemingly small differences in the set-up of the licensing system may have an important influence on how PHTs engage in this arena. This is likely to be of interest to those considering the design and implementation of licensing regulations in similar permit-based systems worldwide. Some differences in practice also arose from differing public health views on the appropriateness of liaising with industry actors, beliefs about the legality and necessity of collaborating with other stakeholders, and the value (or futility), from a public health perspective, of trying to influence retail practices in licensed venues. Finally, the data strongly suggest that the support of national bodies such as AFS and PHE (as was) was important in boosting public health interest in alcohol licensing in the period 2012–9.

Additional information

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Contributions of authors

All co-authors reviewed and approved the final text of this paper.

Niamh Fitzgerald (<https://orcid.org/0000-0002-3643-8165>) (Professor of Alcohol Policy/Director of the Institute for Social Marketing and Health, University of Stirling and Principal Investigator for ExILEnS) led the design of the study and on securing funding. She supported recruitment, conducted some structured interviews and contributed to analysis and interpretation of all data. She led on a full draft of the paper following the drafting of interim findings and led on revising the paper following critical team and peer review.

Andrea Mohan (<https://orcid.org/0000-0003-2467-7174>) (Lecturer, School of Health Sciences, University of Dundee) contributed to the design of the study. She co-led recruitment, conducted structured and in-depth interviews and led on the analysis of structured interview data. She contributed to analysis of in-depth interview data. She contributed to interpretation of all findings and led the first draft of findings. She contributed to further drafting and revision of the full text.

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Laura Mahon (Deputy Chief Executive, Alcohol Focus Scotland) contributed to the design of the study and the securing of funding. She contributed analysis and interpretation of structured and in-depth interview data and contributed to drafting and revision of the full text.

Data-sharing statement

This is a qualitative study and therefore the data generated are not suitable for sharing beyond that contained within the report. Further information can be obtained from the corresponding author.

Ethics statement

The study was approved by the University of Stirling Ethics Committee for NHS, Invasive or Clinical Research (NICR 16/17 – 64 and NICR 16/17 – 064A) and the London School of Hygiene and Tropical Medicine Observational/Interventions Research Ethics Committee (14283). NHS Research and Development approval was secured from all NHS Boards for participating PHTs in Scotland. This was not required for PHTs in England, which are based within local government.

Study registration

The study was registered with the Research Registry (researchregistry6162) on 26 October 2020. The study protocol was published in BMC Medical Research Methodology on 6 November 2018.

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List of abbreviations

AFS	Alcohol Focus Scotland	LNL	late night levy
CIA	cumulative impact assessment	LAAA	local alcohol action area
CIP	cumulative impact policy	PHE	Public Health England
CIZ	cumulative impact zone	PHT	Public Health Team
EMRO	early morning alcohol restriction order	RA	responsible authority
ExILEnS	exploring the impact of alcohol premises licensing in England and Scotland	SC	statutory consultee
		SLP	statement of licensing policy

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