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# ‘Give us the real tools to do our jobs’: views of UK stakeholders on the role of a public health objective for alcohol licensing

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ABSTRACT

*Objectives:* This study ascertains the views of UK stakeholders on the actual, and possible, impact of a public health licensing objective in their day-to-day work.

*Study design and methods:* Twenty-eight interviews were conducted with members of public health teams who were actively engaged in alcohol licensing in their local area between 2017 and 2019. Six teams were based in Scotland (where there is a public health licensing objective) and 14 in England (where there is no similar objective).

*Results:* Scottish participants reported that while challenges remained in applying the public health licensing objective, progress had been made and the objective was beneficial to their work. Participants in England felt that an objective would increase the legitimacy, value and impact of their contributions. In both Scotland and England, constructive relationships between PHTs, licensing authorities and other key stakeholders were developing suggesting that PHTs could have a sustainable and positive role in licensing.

*Conclusions:* In many Scottish areas, the alcohol licensing system is evolving to take constructive account of its public health objective. In England, PHTs that have invested resources in engaging in this area have demonstrated an ability to work effectively within licensing systems. Strong support for the adoption of a public health licensing objective among these PHTs adds weights to calls for the UK Government to reconsider its previous decision not to introduce such an objective.



## Introduction

In the UK, alcohol retail is regulated through a system of local licensing. In England and Scotland, separate primary legislation empowers local authorities to decide whether to grant licences, and what conditions to place on licences that are approved. Although England and Scotland introduced similar reforms to licensing in 2003 and 2005 respectively, recent alcohol policy in Scotland has adopted a stronger public health focus.[1–4] This has led to key policy divergences, including the adoption of minimum unit pricing for alcohol in Scotland, that reflect not only greater political consensus on the need to tackle alcohol-related harms (which have historically been higher in Scotland) but also a desire on the part of the devolved administration to adopt distinctive public health policies relative to the rest of the UK.[5–7] The legislation introduced in 2003 and 2005 established the principle that licence applications should be approved unless they risk contravening specific ‘licensing objectives’. In England and Wales, those objectives are as follows: the prevention of crime and disorder; the protection of children from harm; the protection of public safety; and the prevention of public nuisance. Scottish licensing has four similar objectives, but also ‘protecting and improving public health’. The inclusion of this ‘fifth’ licensing objective in the 2005 Licensing (Scotland) Act is an early example of alcohol policy divergence in regard to the role of public health, which has created a significant difference in the operational framework for licensing between the two nations. Both systems create ‘responsible authorities’ (RAs) who have a formal role as respondents to individual licensing applications and as key

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consultees in the development of local licensing policies. Local public health teams (PHTs) were included as RAs from 2011 in Scotland and 2012 in England.[8,9] The addition of PHTs as RAs led to regional and national action to support public health involvement in licensing.[10–12]

In 2018, 97% of licence applications in both England and Scotland were successful.[13,14] Nevertheless, the 2003 and 2005 Acts set out instruments to address high alcohol outlet densities. Every five years licensing authorities must produce Statements of Licensing Policy (SLP) establishing the policy framework for licensing decisions. In Scotland, SLPs must include a statement identifying any areas considered 'overprovided' with alcohol outlets.[1] In England, local authorities may, but are not required to, create Cumulative Impact Zones (CIZ) following consultation.[2] In overprovision areas and CIZs, the presumption that new licences will not undermine licensing objectives is reversed, and applicants must demonstrate that this will not be the case. In 2012, the UK Government committed to exploring the introduction of a public health licensing objective in England and Wales specifically linked to cumulative impact policies.[15] However, the proposal was dropped following consultation on the grounds that 'local processes and data collection are insufficient, meaning that it is unclear how this proposal could be implemented in practice'.[16]

In Scotland, implementation of the public health licensing objective is supported by advocacy and structured guidance from Alcohol Focus Scotland (AFS), a national organisation campaigning for policies to reduce alcohol harm.[10,17–19] It produces key reports, national events and guidance aimed at ensuring PHTs play an active role in licensing practice. In England and Wales, regional advocacy organisations have supported local PHTs in licensing activity while also campaigning for the establishment of a public health objective.[20,21] Public Health England (PHE) and the Local Government Association (LGA) have both actively supported public health involvement in licensing.[12,22,23] PHE also supported pilots to test the feasibility of a public health objective following the creation of Local Action Alcohol Areas in 2016.[24–26]

Previous research has found that the omission of a public health objective from English legislation undermined PHT's influence on licensing.[27–30] PHTs in England reported experiencing low status within the licensing system, though some had developed working relationships with other RAs. In Scotland, some PHTs reported difficulties applying the public health objective, partly due to naïve expectations around how public health evidence would impact decision-making within a complex licensing system.[31,32] Wright (2019) found some Scottish PHTs felt that the failure of licensing boards to routinely prioritise health considerations showed insufficient accountability to the intentions of the primary legislation.[33] Public health engagement in Scotland has varied, with influence often dependent on the support of local champions within the licensing system.[34] Grace et al. (2016) found that English PHTs struggled to make their input relevant to individual outlets, and so have tended to focus more on area-level interventions such as SLPs and CIZs.[35] Among more active PHTs, a range of approaches to engagement have emerged ranging from 'challenging' engagement, aimed primarily at reducing availability, to more pragmatic, collaborative forms of partnership working aimed at ensuring best use is made of local public health data to improve local outcomes.[20,36,37]

This article focuses on findings from a multisite study of stakeholder opinions using qualitative research methods, which forms part of the Exploring the impact of licensing in England and Scotland (ExILEnS) study.[38] One focus of this study was PHT views on the role of a public health objective in supporting engagement with licensing teams. This is the first qualitative study of this question covering, and comparing, both England and Scotland.

## Methods

In 2017–18, with support from PHE and AFS, all PHTs in England and Scotland were informed of the proposed study via email and invited to participate.[38] Of 44 PHTs who expressed an interest, 40 were selected to ensure the sample was representative of 1) diversity of regionality and urban/rural setting, and 2) relative intensity of PHT activity in licensing in the period 2012–8. The profile of participating areas is summarised in Table 1. The relative intensity of PHT activity was ascertained through desk research (local policies and published case studies) advice from expert partners (e.g. PHE) and scoping interviews with potential participants. Our study protocol, including the sampling strategy, was published at the start of the project.[38] At the sampling stage, 'higher' activity was determined broadly through actions such as allocating dedicated PHT resources to licensing issues, routine analysis of relevant data, having contributed to reviews of licensing policy, or having made representations regarding premises licence applications. A detailed measure of activity intensity was developed postrecruitment to allow quantitative assessment of the relationship between PHT licensing input and health outcomes, which is reported elsewhere[40] The sample was split into 20 'high' and 20 'low' intensity areas, though one lower activity area did not participate in data collection leaving 39 areas in total. For this study, the 20 'high' intensity areas were selected to qualitatively explore the experiences of professionals where efforts towards engagement had occurred. Of these, 14 PHTs were in England and six in Scotland.

For each study area, potential interviewees were identified through direct contact, site visits and snowball sampling. We aimed to recruit participants with strategic leadership roles in regard to PHT engagement with licensing in their area. Twenty-eight participants were recruited across the 20 areas (1 PHT interviewee in 20 areas; 2 in 7 areas, 3 in 1 area). In single areas where relevant roles were split or shared across posts, we aimed to speak to all key individuals. A topic guide was developed based on preliminary desk research and following discussions within the research team (Supplementary file 1).

Participants took part in an in-depth, audio-recorded, one-to-one interview lasting between 32 and 156 min (median: 72 min). Interviews were transcribed, anonymised and imported into NVivo 12 for analysis. Coding against thematic categories was carried out using deductive (reviewing research questions and topic guide) and inductive (transcript analysis) approaches. Codes were developed iteratively, with ongoing refinements based on data re-examination and reflective team discussions.

All participants were provided with an information sheet and had the opportunity to discuss the study with the team before consenting to take part. A consent form was completed on behalf of the team 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.

## Results

### *Making public health an equal partner in the licensing system*

The premises-based focus of licensing means that PHTs face challenges in influencing decisions, especially compared to the police – who have routine involvement with licensed premises in their area.[30] English interviewees consistently described feeling that public health remained, at best, a junior partner in the licensing process. The lack of a public health objective exacerbated this perception:

**Table 1**
Profile of participating areas.

| England (n = 27) | Scotland (n = 12) |
|---|---|
| London and South East 11 | West 6 |
| North West 6 | East 4 |
| North East and Yorkshire 4 | Northeast 2 |
| South West 3 | |
| East 3 | |
| **Local authority type** | Type of local authority is not applicable in Scotland. |
| Unitary: 13 | |
| Lower tier: 14 | |
| **Urban-rural classification** | Urban rural classification not provided for Scotland as it would be likely to identify participating areas. |
| 1 (most rural): 1 | |
| 2: 2 | |
| 3: 5 | |
| 4: 13 | |
| 5: 0 | |
| 6 (most urban): 6 | |

*Having health as a licensing objective is not the be all and end all, but I think it would help significantly in terms of Public Health's role as a responsible authority. And I think that's the key issue. If we're a responsible authority, then give us the real tools to do our jobs effectively […] It feels like we're a responsible authority without any teeth really. (Area 23, England)*

*If health or public health was a licensing objective […] it would strengthen the amount of work that goes on. It would raise the profile and it would also mean that we would be probably respected as much as if the police put in […] a representation. (Area 16, England)*

Scottish interviewees, while recognising the ongoing limitations of their role, noted the positive operational impact of having a public health objective, with many feeling it was essential to their work:

*I can't underestimate the value of it being written down […] with it being within a law. […] It probably does make it easier in one sense to certainly quote something when you're challenging an application, and it gives it the weight of the research. That's behind why that's an objective in the first place (Area 28, Scotland)*

Previous research has highlighted the challenges in applying the public health objective in Scotland.[31,34,41] Participants remained conscious of limitations in the applicability of the public health objective, especially when there was a need to make claims about causal links between individual premises and health outcomes. However, participants also reported that it gave their engagement a vital degree of statutory weight. There was evidence that early challenges were being resolved in some areas, and modes of practice were adopted, which made the application of the objective more practical and meaningful. Several Scottish PHTs reported that involvement in the development of local SLP, including the establishment of 'overprovision' areas, had improved over time as more sustainable structures for advanced planning with partners developed. In other cases, PHTs felt that they had established stronger working relationships within key bodies, such as the Local Licensing Forums:

*One of the things that's been really successful is, first of all, the Local Licensing Forums: our role in the Local Licensing Forums. It's been consistent from the very start, and we've had Public Health representation … I really think that's helped drive the public, the licensing forum forward (Area 19, Scotland)*

While not leading to the kind of availability reductions that some people within Scottish PHTs may have initially hoped for, there was a growing sense that PHT engagement could contribute in less direct ways to improvements in licensing practice.

### *Moving upstream*

Early experiences of Scottish PHTs highlighted the difficulty of establishing causal relationships between single outlets and public health outcomes.[35,41,42] Consequently, it became clear, in both England and Scotland, that public health engagement was likely to be most relevant to area-level considerations – even while premises-specific input remained an option. This meant moving the focus upstream to look at overprovision, CIZs and SLPs.

*I think for a while people thought we were talking about removing licenses. And that's obviously not something that's possible through legislation. But what we can do is say 'Actually we have enough, and we don't think there is a requirement for any more.' So, and again it's that shift isn't it: from looking at it from a case-by-case basis to actually thinking about the wider, whole population approach (Area 34, Scotland)*

While PHT involvement at area level was expected to have a tangible impact – through, for instance, supporting the establishment of overprovision and cumulative impact policies – interviewees also saw a key role for public health in 'setting the scene' for licensing decision-making. That is, providing the broader health-related evidence needed to place individual applications, or policy decisions, in context:

*So, we just generally […] set the scene. So, we'll talk about issues in that particular area, in that particular ward, where the licence application's coming from; look at deprivation, health related information, and any particular concerns we've got with the application. (Area 26, England)*

For English interviewees, the capacity to have an impact at a strategic level was constrained by the lack of a public health objective. By contrast, Scottish interviewees felt the existence of a

public health objective made a significant difference to their ability to influence area-level planning:

> *Getting people to start thinking, or boards to start thinking, a bit wider than just the case by case. So, I think that has been a challenge. But to be fair, having that objective in there has really been supportive for us. (Area 34, Scotland)*

> *[The public health objective] probably does make it easier […] it probably adds to the confidence of an individual licensing board. (Area 28, Scotland)*

Interviewees in England also felt that placing public health considerations on a more formal statutory footing would help applicants and, potentially, reduce the need for representations to be made:

> *It would help in terms of supporting us making the case from the health perspective. But actually, I think if it was actually there, it's that more upstream effect. So, when people are actually putting the licence application in, they're going to be thinking themselves about what they're doing. (Area 39, England)*

A public health objective was not, therefore, seen in narrow terms as an instrument by which to prevent licence applications from being approved. Rather it was viewed as a means of further embedding public health considerations within the licensing systems, ensuring they were given equal weighting with crime prevention, nuisance and the protection of children.

*Developing partnerships with responsible authorities*

Interviewees in both England and Scotland reported establishing partnerships, or working collaboratively, with other RAs. For some, this was experienced as an inevitable consequence of PHT involvement rarely being, by itself, sufficient to generate action. It was reported variously that the lack of a public health objective is a 'frustration' (Area 16, England) that 'hinders [PHT activities] to a degree' (Area 26, England) and causes representations to 'feel a little contrived' (Area 27, England).

> *From the start, we're tied into that grid that we don't actually fit in, and we've come in with a crime and disorder hat because we had some data that helped. So, I think that has been restricted. (Area 25, England)*

For others, however, collaboration was seen as enabling stronger representations to be developed, while helping to ensure that public health considerations were established as routine within the thinking of key decision-makers:

> *I think the most successful way to manage or regulate alcohol under a Licensing Act is actually to have several responsible authorities working together. And that's where you get your real success in the Licensing Committee: when, rather than going as just one Responsible Authority, you get three or four coming. (Area 38, England)*

In areas in England where PHTs had made efforts to engage in a sustained way, collaboration and coordination not only helped provide a route for public health evidence to influence decision-making but also established PHTs as trusted and constructive partners in the wider network of RAs and other key stakeholders.

*Developing a meaningful role in the licensing system*

Interviewees in England reported finding pragmatic ways to develop a meaningful role within the licensing system, albeit without having the degree of autonomy and power that they may have preferred. Some were satisfied with the role as it stood under the current legislation. Most, however, reported that while such arrangements were constructive, they were workarounds put in place to mitigate the limitations caused by the lack of a public health objective.

> *Not having a licensing public health objective doesn't stop us doing what we do. But, just having a public health objective, would make it easier. So, when I say it's a frustration, it would just be that it would give us the ability to make things easier for us. But actually, what we do is that we use those licensing objectives that we've got and use them creatively. (Area 38, England)*

Therefore, while frustrated by the lack of a public health objective, pragmatic strategies were being developed that allowed for a level of meaningful engagement. Interviewees understood that the realistic impacts were constrained not only by the lack of a public health objective but also by well-established norms of decision-making in this setting. They did not see a public health objective as uniquely transformational, but rather as a necessary contribution to a broader strengthening of public health considerations in this area.

## Discussion

*Main findings of this study*

Our findings show strong support among participating PHTs in England for the introduction of a public health objective for licensing in England and Wales. Interviewees felt it would raise the profile of public health within the licensing system, enable a more proactive consideration of how premises could operate more responsibly, and provide structure and legitimacy to both representations and strategic engagement. Many felt that a public health licensing objective would also better enable the use of health data – such as alcohol-related harm trends, A&E visits, or ambulance call-outs – to inform planning and policy. The adoption of a public health objective in Scotland, and its significance as part of a broader public health-oriented suite of alcohol policies, clearly provided an aspirational model for public health professionals in England. Participants were pragmatic, however, in regard to what was achievable. Few felt such an objective would (or necessarily should) significantly reduce outlets in a given area, especially in the short term; rather it would help develop a practice culture in which public health was a routine consideration. Interviews demonstrated that strong and constructive partnership-working between PHTs, licensing authorities and other Responsible Authorities was possible despite differences in approach, priorities and the uses of evidence.

*What is already known on this topic*

Previous studies have found that public health professionals experience frustration when engaging with alcohol licensing, and that they often feel undervalued in the process.[27–30,33,35] Some PHTs have held naïve, or overly optimistic, expectations about their potential impact, while others have taken a more pragmatic view of their role in a complex system that applies different approaches to evidence.[20,31,32,43,44] Previous reviews of the operations of the public health licensing objective in Scotland have found that

implementation was often hampered by lack of clear understanding of how the objective could be applied in practice and friction between PHTs and licensing teams.[17,31,34,45]

*What this study adds*

This is the first study of the debate over a public health objective to compare experiences of Scottish and English PHTs in the context of changes over time. Responses from Scottish participants here suggest early challenges have, to some degree, been addressed: PHTs in Scotland routinely provide input into local SLPs and have become increasingly confident in establishing a sustainable and constructive role, making use of the public health objective – including in support of the establishment of 'overprovision' areas. English PHTs also reported developing increasingly constructive relationships with other Responsible Authorities. However, in England, there remains a widespread perception that the ability to influence both decision-making and strategic policy is hampered by the lack of a public health objective.

*Limitations of this study*

Interviews on this topic were only carried out with PHTs that were deemed to have been actively engaged with licensing during the study period. Therefore, they represent the experiences of teams that had invested significant capacity and resource into licensing activity. The experiences of PHTs that were not actively engaged in licensing, whether due to lack of capacity, resource or motivation cannot be inferred directly from this data. The selection of only 'high' intensity areas creates a risk of participant responses being biased towards either emphasising success or providing information useful to a study perceived as oriented towards supporting the creation of a public health licensing objective. To mitigate this, our interview questions invited reflection on both positive and negative experiences, including unintended consequences; and participants were not guided specifically to comment, or take a position on, a public health licensing objective (though it was a prompt option for a general question on possible changes to the licensing system). Possible biases within the research team were considered throughout the data analysis and interpretation stage, and we sought to address these through reflective discussion.

*Conclusions*

These findings suggest relationships between diverse stakeholders in licensing in Scotland are developing constructively. However, while relationships are also developing in England, active PHTs continue to express frustration that their contribution is hampered by the lack of a public health objective, which necessitates procedural workarounds that create unnecessary barriers and blockages. These barriers, and the lack of presumed legitimacy, may partly account for the number of areas in England where engagement among PHTs remains low – though there remain areas of low engagement in Scotland too. At the same time, this study demonstrates that public health evidence can be usefully deployed in the licensing context, and that in many areas a culture of collaborative working has developed, which has allowed public health considerations to become a core feature of licensing activity. In 2013, the reason given by the UK Government for not implementing its proposal to create a health-based licensing objective for cumulative impact assessment was that 'more work is required at local level to put in processes to underpin it'.[16] This research suggests that such work is underway, and that in areas where this has occurred, PHTs are keen for the UK Government to reconsider following Scotland in putting public health considerations on a statutory footing.

## Author statements

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*Ethical approval*

The study was approved by the University of Stirling Ethics Committee for NHS, Invasive or Clinical Research (NICR 16/17 – 64) and the Research Ethics Committee at London School of Hygiene and Tropical Medicine (LSHTM 14283/RR/8365).

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*Competing interests*

James Nicholls was previously employed by Alcohol Change UK and has worked with Public Health England in an unpaid advisory role on alcohol licensing issues.

Laura Mahon is employed as Deputy Chief Executive of Alcohol Focus Scotland (AFS). AFS is a registered Scottish charity (SC009538) with the stated aim of reducing the harm caused by alcohol in Scotland.

Niamh Fitzgerald has received research or other support from charities and other organisations working to reduce harm from alcohol or on related issues including Scottish Health Action on Alcohol Problems, the Institute of Public Health in Ireland, Public Health Scotland, the Society for the Study of Addiction, and Alcohol Change UK.

*Authors' contributions*

JN, writing (original draft preparation); ROD, NF and LM, writing (editing and reviewing); NF, ROD, JN and LM, conceptualisation and methodology; NF, ROD and the ExILEnS Consortium, investigation, data collection and formal analysis; and NF, JN, LM and the ExILEnS Consortium, funding acquisition. All authors have approved this submitted version.

*Data availability*

All data requests should be submitted to the corresponding author for consideration. Access to anonymised data may be granted following review.

## Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.puhe.2022.07.006.

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