

# How public health teams navigate their different roles in alcohol premises licensing: ExLlEnS multistakeholder interview findings

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# Abstract

## How public health teams navigate their different roles in alcohol premises licensing: ExLEnS multistakeholder interview findings

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**Background:** In England and Scotland, local governments regulate the sale of alcohol by awarding licences to premises to permit the sale of alcohol for consumption on or off the premises, under certain conditions; without such a licence, alcohol cannot be legally sold. In recent years, many local public health teams have become proactive in engaging with alcohol licensing, encouraging licensing authorities to act in ways intended to improve population health.

**Objective:** This research aimed to explore and understand the approaches and activities of public health stakeholders (i.e. NHS staff and other public health professionals) in seeking to influence local alcohol licensing policy and decisions, and the views of licensing stakeholders (i.e. licensing officers/managers, police staff with a licensing remit, elected members and licensing lawyers/clerks) on the acceptability and effectiveness of these approaches.

**Participants:** Local public health teams in England and Scotland were directly informed about this multisite study. Scoping calls were conducted with interested teams to explore their level of activity in alcohol licensing from 2012 across several categories. Twenty local authority areas with public health teams active in licensing matters were recruited purposively in England ( $n = 14$ ) and Scotland ( $n = 6$ ) to vary by region and rurality. Fifty-three in-depth telephone interviews (28 with public health stakeholders and 25 with licensing stakeholders outside health, such as local authority licensing teams/lawyers or police) were conducted. Interview transcripts were analysed thematically in NVivo 12 (QSR International, Warrington, UK) using inductive and deductive approaches.

**Results:** Public health stakeholders' approaches to engagement varied, falling into three main (and sometimes overlapping) types. (1) Many public health stakeholders in England and all public health stakeholders in Scotland took a 'challenging' approach to influencing licensing decisions and policies. Reducing health harms was felt to necessitate a focus on reducing availability and generating longer-term culture change, citing international evidence on the links between availability and alcohol-related harms. Some of these stakeholders viewed this as being a narrow, 'nanny state' approach, whereas others welcomed public health expertise and its evidence-based approach and input. (2) Some public health stakeholders favoured a more passive, 'supportive' approach, with some reporting that reducing availability was unachievable. They reported that, within the constraints of current licensing systems, alcohol availability may be contained (at least in theory) but cannot be reduced, because existing businesses cannot be closed on availability grounds. In this 'supportive' approach, public health

stakeholders supplied licensing teams with data on request or waited for guidance from licensing teams on when and how to get involved. Therefore, public health action supported the licensing team in their aim of promoting 'safe' and 'responsible' retailing of alcohol and/or focused on short-term outcomes other than health, such as crime. (3) Some public health stakeholders favoured a 'collaborative' approach in which they worked in close partnership with licensing teams; this could include a focus on containing availability or responsible retail of alcohol, or both.

**Conclusions:** In engaging with alcohol licensing, public health stakeholders adapted their approaches, sometimes resulting in a diminished focus on public health goals. Sampling did not include lower-activity areas, in which experiences might differ. The extent to which current licensing systems enable achievement of public health goals is questionable and the effectiveness of public health efforts merits quantitative evaluation.

**Study registration:** The study is registered with the Research Registry as researchregistry6162.

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# List of abbreviations

ExILEnS	Exploring the Impact of Licensing in England and Scotland	SLP	statement of licensing policy
NIHR	National Institute for Health and Care Research		



## Plain language summary

In England and Scotland, bars, restaurants and shops can sell alcohol only if they are given a licence by their local government. In recent years, NHS staff and other public health professionals, or 'public health stakeholders', have tried to positively influence the system that decides who should get these licences.

This study aimed to understand how these stakeholders have worked with the licensing system, and what people who were already working in the licensing system, or 'licensing stakeholders', think of their approaches.

A total of 53 interviews were conducted in 20 varied local government areas in England (14 interviews) and Scotland (six interviews). Twenty-eight of these were with public health stakeholders and 25 were with licensing stakeholders, including local government lawyers or police. Interviews were transcribed (typed out) and studied carefully to understand what was being said.

Public health stakeholders took three different approaches to their work with the licensing system. (1) Many public health stakeholders took a 'challenging' approach, trying to make alcohol less easily available and to change drinking culture over the long term. They felt that this was in line with research evidence, but some licensing stakeholders felt it was a narrow, 'nanny state' approach. (2) Other public health stakeholders were less active, providing data or other support to licensing teams or police colleagues only when asked. They reported that they did not think that it was not possible to make alcohol less available through licensing and that their support instead helped licensing teams to promote good management of bars and shops and to prevent crime or disorder. (3) Some public health stakeholders worked actively in close partnership with licensing teams.

Public health stakeholders adapted their approaches to working with alcohol licensing, sometimes resulting in a reduced focus on improving health. These approaches should be tested to see which approach works best. However, current licensing systems may not be able to improve health.





# Background and introduction

Alcohol consumption in England and Scotland remains high compared with historical estimates and levels of consumption elsewhere in the world.<sup>1</sup> The legal sale of alcohol requires a premises licence, which is granted by a licensing authority linked to local government.<sup>2,3</sup> Limiting the sale of alcohol in this way is central to regulating the availability of alcohol. It has important implications for public health because greater availability is associated with more alcohol-related harms.<sup>4,5</sup> Although several guidance documents are available,<sup>6-8</sup> there is a lack of evidence to guide public health stakeholders (i.e. NHS staff and other public health professionals) on the most effective approaches to engage with this local licensing system to achieve public health goals.<sup>9</sup>

Recent regulatory changes in the licensing systems in England and Scotland have given health representatives a formal role. The degree to which local public health stakeholders and teams engage with this process varies by locality in (and likely between) both nations, which have similar licensing systems.<sup>10</sup> Both systems require that decisions and policy are guided by the following objectives: to (1) prevent crime and disorder; (2) promote public safety; (3) prevent public nuisance; (4) protect children (and young people) from harm; and, in Scotland but not yet in England, (5) protect and improve public health.

There are several key stakeholders and structures in licensing systems ([Table 1](#)), including the licensing committee or 'board' (comprising 5–10 local councillors or 'elected members'), the chairperson or 'convener' (Scotland), a lawyer or licensing 'clerk' (Scotland), the local authority licensing team

TABLE 1 Key stakeholders in the licensing systems in England and Scotland

Key stakeholder	Definition	
	England	Scotland
Licensing committee/board	The licensing committee comprises 10–15 local 'councillors' (i.e. elected members of the local government, which is known as the 'local authority' or 'council'). Councillors are appointed to the board for a term of 4–5 years by the local authority	The licensing board comprises 5–10 local 'councillors' (i.e. elected members of the local government, which is known as the 'local authority' or 'council'). Councillors are appointed to the board for a term of 4–5 years by the local authority
Chairperson/convener	The licensing committee elects its own 'chair', who has the casting vote in decisions	The licensing board elects its own chairperson – the 'convener' – who has the casting vote in decisions
Local licensing forum	N/A	Local licensing forums were established (in Scotland only) under the 2005 Act <sup>3</sup> to ensure that community stakeholders have an active voice in scrutinising the operation of licensing in their area. Each licensing board area should have a forum to advise and make recommendations to the licensing board. Forums comprise 5–21 members, including at least one licensing standards officer and a health board representative. In addition, forums often include licence holders; education, social work and police representatives; local residents; young people; and licensing board members
continued		

**TABLE 1** Key stakeholders in the licensing systems in England and Scotland (*continued*)

Key stakeholder	Definition	
	England	Scotland
<b>Licensing stakeholders</b>		
Licensing lawyer/clerk	A licensing lawyer, employed by the local council, provides legal support to the licensing committee	A licensing clerk is a lawyer, employed by the local council, who provides legal support to the licensing board
Licensing officers and managers (England); managers/ licensing standards officers (Scotland)	Licensing officers, employed by the local council, provide guidance to licensees (those holding a licence to sell alcohol), mediate in disputes and ensure compliance. Licensing managers manage the process and licensing team	Licensing standards officers, employed by the local council, provide guidance to licensees (those holding a licence to sell alcohol), mediate in disputes and ensure compliance
(Locally) elected members	Locally elected councillors, who may sit on the licensing board, represent the interests and multiple needs of the local community	Elected members of the local government, who may sit on the licensing board, including ward councillors, represent the interests of the population of the local authority (not just their ward)
Police licensing officers (England); police officers (Scotland)	The role of police licensing officers is to supervise licensable activities in their jurisdictions, seeking to reduce harm and uphold the licensing objectives	The role of police officers is to work with local authorities and other relevant partners in the administration and enforcement of licences and registrations to reduce crime, violence and disorder
Other statutory stakeholders	Depending on the type of licensing application, applicants should send copies to the following 'responsible authorities': the police, local fire and rescue, relevant primary care trust or local health board, relevant licensing authority, local enforcement agency for the Health and Safety at Work etc. Act 1974, <sup>11</sup> environmental health authority, planning authority, body responsible for the protection of children from harm, local trading standards, Home Office Immigration Enforcement (on behalf of the Secretary of State) and any other licensing authority in whose area part of the premises is situated	For each licensing application or variation application received, the board must seek information and evidence in writing prior to the licence hearing from 'statutory consultees'. Statutory consultees include Police Scotland, licensing standards officers, environmental health and the local health board
N/A, not applicable. Adapted with permission from Fitzgerald <i>et al.</i> <sup>10</sup>		

responsible for administering the system, and, in Scotland only, the local licensing forum. In Scotland, licensing boards must produce a statement of licensing policy (SLP) every 4 or 5 years and are required to consult publicly on their proposed policy. SLPs must include an overprovision statement (i.e. whether or not there are local areas where the number or density of outlets selling alcohol is deemed excessive). In overprovisioned areas, new licence applications may be refused on the grounds of overprovision unless the applicant can demonstrate that granting the licence would not undermine the licensing objectives. In England (and Wales), local licensing policies are reviewed every 5 years, or more often if prompted by the licensing authority, and must also be consulted upon. A non-statutory right exists to create cumulative impact zones, which work somewhat similarly to overprovision areas and have been associated with small reductions in alcohol-related hospital admissions and crimes.<sup>12,13</sup>

Few recent studies have explored stakeholders' perceptions of the role of public health in alcohol licensing and these have been limited to exploration in a relatively small numbers of local areas. Reynolds *et al.*<sup>14</sup> examined public health contributions to licensing decision-making in eight local

authorities in England and found that some public health teams considered the licensing role to be important for shaping the local alcohol environment, whereas others perceived little capacity to influence licensing decisions. Broader discussion is required among licensing stakeholders (i.e. licensing officers/managers, police staff with a licensing remit, elected members and licensing lawyers/clerks) about the role of public health in the licensing process to develop understanding of the potential and value for public health contributions, and strengthen them accordingly.<sup>15</sup> Somerville *et al.*<sup>16</sup> reported that, in a qualitative study in six London boroughs, most public health interviewees agreed that partnership working with licensing colleagues was the ideal situation. Some felt that integrating into existing partnerships at the local level was hard to achieve, and licensing colleagues reported confusion about the role of public health in licensing. Awareness of differences due to economic, opportunistic, organisational and personnel factors particular to each local authority is also key to guard against imbalances in licensing policy choices; Mooney *et al.*<sup>17</sup> suggest that these factors can lead to substantial local differences in prioritisation of alcohol harm prevention strategies. Confusion about the role of public health was also found in early work with licensing stakeholders in Scotland after the introduction of the public health objective.<sup>18</sup> The most recent qualitative study in Scotland included 13 public health teams and gathered data in 2013/14.<sup>10,19</sup> This study found that the introduction of the public health objective for alcohol premises licensing was viewed by many public health professionals as aiming to reduce population-level alcohol consumption, and some reported challenges in engaging with the licensing system on this basis. Building positive working relationships with licensing stakeholders over a prolonged period was often viewed as key to progress.<sup>19</sup>

To our knowledge, no previous study had been conducted in a large and diverse sample of local authority areas across Scotland and England, offering the opportunity to explore and compare differing public health approaches and the views of licensing stakeholder on a relatively large scale. Therefore, as part of the ExILEnS (Exploring the Impact of Licensing in England and Scotland) study<sup>20</sup> we sought to explore and understand public health stakeholders' approaches and aims in engaging with alcohol licensing, including their rationale, and the views of licensing stakeholders on the acceptability and value of these approaches.



# Methods

## Context

This report focuses on findings from a multisite study of stakeholder opinions using qualitative research methods, which forms part of the wider ExILEnS study.<sup>20</sup> The ExILEnS study aims to describe, explore and critically assess public health stakeholders' engagement in alcohol premises licensing, and the resulting impact (if any) on alcohol-related harms, in local areas with differing types and intensities of engagement.

## Sample and recruitment

In accordance with our protocol,<sup>20</sup> we recruited public health teams covering 20 'higher-activity' areas (England,  $n = 14$ ; Scotland,  $n = 6$ ), defined as areas in which the public health team had been actively seeking to influence alcohol licensing for most or all of April 2012 and during the recruitment period (2017–19). In Scotland, Alcohol Focus Scotland (a national organisation that supports public health stakeholders on alcohol licensing) advised on sampling to enable recruitment of six higher-activity public health teams working in diverse areas. Three Scottish island authorities were not eligible for inclusion because of the relatively small number of licence applications under consideration. In England, we directly informed all public health teams about the study, inviting expressions of interest, and conducted scoping calls with interested teams to explore their level of activity in engaging with alcohol licensing. Areas were identified as higher-activity areas at recruitment through consideration of self-reported activity from public health teams in brief scoping calls, advice from the Study Steering Committee and publicly available information on involvement in other licensing initiatives (such as the Home Office initiative Local Alcohol Action Areas).<sup>21,22</sup> Selection primarily focused on those areas with sustained, high-intensity public health team engagement in licensing from the earliest time point. We recruited 14 higher-activity areas in England, which varied purposively in terms of region and rurality. A detailed profile of participating public health teams, including the average index of multiple deprivation (2012–18), alcohol-related hospital admissions and public order offences, is reported separately. One recruited team dropped out owing to a public health crisis and was replaced.

In these 20 areas, potential stakeholders for interview were identified through direct contact, initial site visits (undertaken as part of the wider ExILEnS study) and snowball sampling. We aimed to recruit up to 80 public health and licensing stakeholders, with at least one interview conducted in each of the 20 recruited higher-activity areas, in accordance with our protocol.<sup>20</sup> Purposive participant selection aimed to optimise diversity in terms of public health stakeholder and licensing stakeholder remits. Licensing stakeholders were often identified through participating public health professionals and then approached for recruitment. All individuals were assured that the information that they would provide was confidential and that they could withdraw from the study at any point. Informed consent was obtained prior to each interview.

## Data collection

Members of the research team (RO, AM, RP and NM) conducted the interviews by telephone between November 2018 and October 2020. Fifty-five individuals agreed to participate; two were uncontactable to arrange interviews. In discussion with our Study Steering Committee, we made a pragmatic decision

to end recruitment after conducting 53 stakeholder interviews, because all recruitment leads had been explored by this point. Five interview topic guides were developed, tailored to each stakeholder type [i.e. public health, licensing managers/officers, elected members, police (licensing) officers and licensing lawyers/clerks] and based on existing alcohol licensing literature and research team discussions. Topic guides comprised open-ended questions, including a focus on interviewee roles, responsibilities and purpose in the licensing system, public health approaches to engaging in licensing and interviewee views on such approaches ([Boxes 1](#) and [2](#) contain example questions). Interviews were audio-recorded and lasted between 32 minutes and 2 hours and 36 minutes (median duration 1 hour and 12 minutes).

### Data analysis

With participant permission, interview recordings were professionally transcribed and then anonymised and imported into NVivo 12 (QSR International, Warrington, UK) for analysis. Members of the research team (RO, AM and RP) coded transcripts against a set of categories created using deductive approaches (i.e. reviewing research questions and topic guides) and inductive approaches (i.e. reading transcripts). These categories were developed iteratively, with ongoing refinements on the basis of re-examining data and reflexive team discussions. After initial coding, extracts on topics of relevance to our research aim were reviewed in detail by a team member (RO) in discussion with another (NF). A team member (RO) wrote up interim analysis findings, which were then reviewed and refined in discussion with other team members (NF, ME, AM and RP, who had each conducted interviews, read transcripts or both) and with input from the Study Steering Committee, consisting of expert academics and practitioners in this field as well as lay representatives. Analyses were also conducted using this data set, as well as separate structured interview and documentation data, to explore how engagement, processes, approaches and outcomes vary between Scotland and England, and these findings are reported in forthcoming publication.<sup>23</sup>

#### BOX 1 Summary of relevant interview questions: public health team topic guide

1. Role and experience
  - Job title/post
  - Briefly describe main duties, especially your duties relating to alcohol licensing
  - How many years have you been in post and involved in alcohol licensing work?
  - Who else works with you on this? What is the team set-up?
2. Public health team activity
  - When you respond to a licensing application, what are you trying to achieve?
    - How does the way in which you respond maximise achieving [X]?
    - In what way does your response lead to a licence being declined or accepted?
  - When inputting to a SLP, what are you trying to achieve?
    - How does what you do lead to a stronger SLP? What does that achieve?
  - When networking with other responsible authorities and the licensing team, what are you trying to achieve?
    - How does what you do impact on licensing processes or decisions?
    - Is your activity leading to changes in the licensing system or just helping the existing process? How?
3. Public health team views on the licensing system
  - What changes would you like to see in the licensing system? [*Prompts: licensing objective; other legislation; political economic changes*]
  - What advice would you give to a public health team that wanted to start getting involved in alcohol licensing?
  - Are there any unintended consequences of what you do?

**BOX 2** Summary of relevant interview questions: licensing stakeholder topic guide

1. Role and experience
  - Job title/post
  - Briefly describe main duties, especially your duties relating to alcohol licensing
  - How many years have you been in post and involved in alcohol licensing work?
  - Who else works with you on this? What is the team set-up?
2. Licensing stakeholder activity
  - On a day-to-day basis, what is the main focus of your work on licensing?
    - What is licensing in your area trying to achieve? How much of what you do relates to each of the licensing objectives?
  - What are you looking for when you review applications? What benefits are you trying to achieve or what harms are you trying to prevent?
  - What does a good SLP look like?
    - What does your SLP seek to achieve? How effective do you think it is and why?
  - How do you or the licensing team engage with other stakeholders in relation to alcohol licensing? *[Prompt for both informal and more formal types of engagement]*
    - What are you trying to achieve through this engagement?
  - Has your approach to licensing changed in recent years? If so, how and why?
3. Views on public health engagement in licensing
  - What is the role of public health in the process (for example, when responding to licensing applications, inputting to SLPs, and working with other responsible authorities)?
  - How/if at all do you work with your local public health teams on this?
  - What does working with the public health team add (if anything)?
  - Can you give examples of when public health and licensing team aims have been aligned or when they have not?
  - How do you work with public health compared with other responsible authorities/statutory consultees?
4. Views on the licensing system
  - What changes would you like to see in the licensing system? Why?

**Public and stakeholder involvement**

As a study of public health practice in the licensing system, the public audience for the study was primarily public health teams and licensing teams across the UK rather than members of the lay public. Therefore, we paid a lot of attention to ensure that these stakeholders were adequately involved in the research. First, representatives from the UK Licensing and Public Health Network and Alcohol Focus Scotland joined our team as co-investigators, alongside a licensing lawyer (based in England), each of whom contributed to team meetings and our thinking throughout the study. Second, our Study Steering Committee benefited from the expertise of the lead for licensing from Public Health England, two licensing lawyers (one based in Scotland and one in England) and a public health practitioner with experience of licensing (based in England). We also involved two lay members of the public, each of whom contributed to the design of the study and data collection methods.

**Ethics**

Ethics approval for the study was granted by the University of Stirling Ethics Committee for NHS, Invasive or Clinical Research (reference NICR16/17-064/064A) and the London School of Hygiene & Tropical Medicine Observational/Interventions Research Ethics Committee (reference 14283). NHS Research and Development approval was secured from all participating NHS boards in Scotland. This was not required for public health teams in England, which are based in local government.





# Results

A total of 53 stakeholders participated (public health stakeholders,  $n = 28$ ; licensing stakeholders,  $n = 25$ ), as shown in [Table 2](#), with interviews conducted in all 20 recruited higher-activity areas.

## Public health approaches to engaging with alcohol licensing systems

Public health stakeholders described a range of approaches to engaging with alcohol licensing systems, which can be broadly described as ‘challenging’, ‘collaborative’ or ‘supportive’. These approaches were not always mutually exclusive; for example, ‘collaborative’ approaches often overlapped with ‘challenging’ approaches taken by public health teams in Scotland. Examples of each approach, and licensing stakeholders’ views on their acceptability and/or effectiveness, are provided in this section, with illustrative quotations.

### Adopting a ‘challenging’ approach with a primary focus on alcohol availability

All public health stakeholders in Scotland, and some in England, reported taking a ‘challenging’ approach to influencing licensing decisions and policies. Reducing health harms was felt to necessitate a focus on reducing availability and generating longer-term culture change, citing international evidence on the links between availability and alcohol-related harms. Several public health stakeholders felt that they could make a difference by broadening licensing decision-makers’ understanding of alcohol-related harms to health. Therefore, this approach involved actively seeking to raise the profile of long-term health harms caused by alcohol in discussions of local licensing policy or decisions. It also involved active objections to licence applications on public health grounds, especially in areas that were considered to be affected by a large number of existing premises:

*I think it’s important that we do consistently respond [to licensing applications] to hold [the licensing board] to account in relation to the overprovision policy. I mean, that’s our job, and it’s set out in legislation [the public health objective]. That’s what we’re supposed to do. We’re supposed to say ‘this is in the overprovision area, this is the health data and we object on the grounds of public health’, and that means that that’s in front of them then and they can either disregard it or not.*  
*Health improvement lead, area 37, Scotland*

TABLE 2 Participant characteristics

Stakeholders	Scotland (n)	England (n)	Total (n)
Public health team members	9	19	28
Licensing stakeholders	15	10	25
Licensing officers/managers	5	4	9
Elected members	2	3	5
Licensing lawyers/clerks	4	1	5
Police licensing officers	4	2	6
Total number of interviews	24	29	53

Licensing stakeholders had mixed views on this approach. In a few cases they felt that a blanket approach to opposing applications in overprovided areas on the grounds of public health was simplistic and unrealistic:

*I think my general advice to them would be, overall, pick the battles that are actually of significance because in the case of [specific licensing application] there was no way members were not going to grant that application and anyone looking at it would have said that.*

*Clerk, area 37, Scotland*

However, this view from licensing stakeholders may also have been influenced by what was reported by public health stakeholders as a focus in the licensing system on economic growth. In some cases this was felt to be a higher priority for licensing boards/committees than reducing alcohol-related harms, and this created a barrier for public health teams who felt the need to try to 'compete' with economic arguments:

*Oh yeah, definitely, we are competing all the time [with the economic argument], because it's, we're a tourist town, aren't we? So it is a real balancing act, because it is about economy, bringing new businesses [such as restaurants and bars] into town, [which] brings tourists in. But then it's competing with, we don't want lots of alcohol premises everywhere.*

*Public health practitioner, area 26, England*

A minority of licensing stakeholders viewed this 'challenging' approach as 'difficult' because of the potential for it to be misconstrued as a 'nanny state' approach, and because of a perceived focus on data and messaging related to long-term alcohol-related harms:

*It's how you do so without being patronising and making it sound like the 'nanny state'. I think that's where public health has difficulties. There's nothing wrong with what they're saying, it's how the message gets received. Because they're right, they're right about all the long-term harm that's being stored up, even by people who are moderate drinkers. We don't know what problem that might cause in 30 years, but there's no way a licensing board is going to take any decision about what might or might not be [a] harm in 30 years' time.*

*Police licensing sergeant, area 32, Scotland*

However, some licensing stakeholders valued public health expertise and their evidence-based approach and input, which one licensing stakeholder described as 'invaluable' (licensing lawyer, area 39, England). The importance of making evidence-based decisions was seen as increasingly important by one licensing stakeholder, specifically in relation to reviewing licensing applications, when asked how their own approach to alcohol licensing had changed in recent years:

*We've probably had to work a bit harder and ensure that what we say is based on evidence and accuracy [since public health's involvement in the licensing process], so that, if we're challenged or if something was to go to an appeal, that, you know, upon scrutiny, it's not just opinion, it has to be more evidence based.*

*Police licensing sergeant, area 37, Scotland*

Evidence-based contributions made by public health stakeholders were also viewed as particularly important in relation to development of local SLPs:

*I think the latest statement [of licensing] policy that we have had has got to be one of the best that we have had ... and that was mainly because we had a lot of involvement with public health in putting forward the recommendations. ... [Public health team member] had a huge involvement in writing and contributing and consulting with that particular document.*

*Licensing manager, area 36, England*

### **Adopting a 'supportive' approach to assist licensing teams in promoting responsible retail of alcohol**

Other public health stakeholders in England favoured a more passive 'supportive' role. Taking this approach, public health stakeholders supplied licensing teams with data when requested, supported representations made by other responsible authorities or waited for guidance from licensing teams on when and how to get involved. Therefore, public health action supported the licensing team in their aim of promoting 'safe' and 'responsible' retailing of alcohol (including by off-licence premises) and/or focused on short-term outcomes other than health (such as crime). This felt more achievable for some public health stakeholders, who often felt that reducing availability was unachievable for licensing committees:

*It's very hard [for licensing committees] to say no to a new [off-licence] premises, even if you're quite sure that it probably will add to the cumulative impact and increase harm. Some of the reason, I guess, is around the legal representation of premises, so big businesses might have more money to fight a case to get their premises set up, compared to what the local authorities would have to challenge that ... and it's also really, really tough to prove that a new premises would cause harm because you've got nothing to base that on and [the applicant], they can say how they're going to prevent that harm occurring.*

*Health programme advisor, area 25, England*

In addition, this 'licensing-friendly' approach enabled some public health stakeholders to distance themselves from the 'nanny state' connotations associated with typically 'challenging' approaches to public health involvement in alcohol licensing:

*It's about promoting sensible drinking, not trying to ban or reduce the level of alcohol sales/ establishments. I think we don't have any kind of rule of thumb around how many sort of establishments we want to see in a particular area, etc. I think as long as they're all well run that would kind of meet our objectives.*

*Health protection lead, area 29, England*

In relation to this 'supportive' approach, a few licensing stakeholders felt that public health could be more proactively engaged in licensing activities, with one stating that 'they make very few representations when I think maybe they could' (police licensing sergeant, area 30, England). Others noted that the lack of a public health objective in England could restrict public health approaches:

*The role of public health is the only slightly grey area ... For them as a responsible body, trying to process applications can be quite tricky ... They have to try and somehow tie statistics into the relevant licensing objectives, which are invariably, public safety or crime and disorder ... I suspect, to a degree, they're very frustrated.*

*Licensing lawyer, area 39, England*

### **Adopting a 'collaborative' approach**

Public health stakeholders adopting a 'collaborative' approach worked in close partnership with licensing teams. This approach was common to teams in England and Scotland, with several public health teams in Scotland taking this approach alongside, or after having tried, a 'challenging' one. The 'collaborative' approach could include a focus on containing availability or the responsible retail of alcohol, or occasionally both:

*I try and focus on both elements [responsible retailing and containing availability]. I take every application on its own merit. Really look at, sort of, the hours that are being applied for. What activity they're wanting to do. What's been put in their operating schedule to counteract some of the things that they are asking for. And it's about doing your best for whatever, or whoever, is within that environment, I suppose, and thinking about the consequences as well. Yes. I don't think anything's got, sort of, more importance.*

*Public health officer, area 38, England*

Public health stakeholders using a 'collaborative' approach often stressed the importance of building relationships with licensing stakeholders. Cultivating a joined-up approach to reviewing licensing applications and the development of SLPs with licensing staff and police colleagues in particular was viewed by some as an effective approach. In one local authority area, a 'collaborative' approach facilitated public health team engagement with local alcohol licence holders, enabling their involvement in promoting responsible alcohol retailing:

*I could not do what I do without working closely with the police and latterly very closely with licensing as well ... I wouldn't be going out doing [off-licence premises] visits without [licensing colleagues], because I've got no powers of entry ... but if I'm with the police or with licensing then I can just go in with them and chat and it's working, it's a really close working relationship.*

*Alcohol harm reduction officer, area 36, England*

In some areas, public health stakeholders spoke of a strategic shift from a 'challenging' approach to a more 'collaborative' approach over time, which focused on joined-up working with licensing teams. This was often shaped by their initial experiences of engagement in alcohol licensing and/or by licensing team involvement:

*We tended to initially ... look at everything and say, can we change this or can we make a comment, and I think we felt that we needed to be a wee bit more targeted, because I think the board were beginning to see the NHS stepping in with lots of little comments and maybe we needed to just save our strength for some of the more important aspects. ... So, we have tried to, I think where possible, make less objections and more representations and suggestions for change to applicants [e.g. the sale of food and not just alcohol in on-trade premises where children are permitted] that would maybe help them work towards [achieving] the public health objective.*

*Health improvement officer, area 32, Scotland*

This shift in approach was also discussed by some licensing stakeholders, who spoke of a 'process of learning' regarding public health team involvement in which they invested time to discuss optimal public health engagement with licensing activities early on:

*Essentially what the problem was, was their applications were ... all to do with local provision. So when they made an objection it's to do with 'there's too much alcohol in the city and if you give this applicant a licence, it's a new premises so it's like more alcohol'. ... And once we all sat down with them and just had a chat with them, they kind of went, 'right, we've got it now'. They just needed to find out where the real parameters were to get it right.*

*Elected member and licensing board convener, area 28, Scotland*

When talking about 'the real parameters', this participant explained that, from the licensing team perspective, public health needed to develop and structure objections 'effectively', instead of making very frequent objections.

In most local authority areas where public health involvement was described as 'collaborative', licensing stakeholders noted that they played an active and vocal role in licensing activities. One licensing stakeholder suggested that public health was the dominant voice in licensing in their local authority area, although this was a minority view among participants:

*Public health here in [area] are very vocal. And, as I say, they also liaise very heavily with other responsible authorities, predominantly the police and licensing. So they sometimes get together and discuss who is going to be putting forward what in terms of any recommendations. It's very public health driven rather than licensing driven.*

*Licensing standards manager, area 36, England*

### Other observations

Although most public health stakeholders were able to articulate their approach to involvement in alcohol premises licensing over the course of the interview, in one case this was unclear, highlighting that clarity of purpose is not a given:

*As I'm speaking now I realise that we've got ... we haven't got a clear narrative of what we're trying to achieve when it comes to licensing of alcohol and premises or access to alcohol.*

*Health programme advisor, area 25, England*

A few others found it difficult to articulate their approach.

Many of the licensing stakeholder interviews were conducted during the COVID-19 pandemic. Although some public health and licensing stakeholders were working more disparately because of lockdown restrictions ('It's just not been practical ... so you don't have that information flow', licensing standards officer, area 23, England), in other areas new working relationships were developing as a result of working on COVID-related matters. One licensing stakeholder who felt that they had not worked effectively with public health prior to the COVID-19 pandemic suggested that this could transfer to new ways of working together on alcohol licensing in the future:

*We've been liaising with public health in the last few weeks in relation to these [COVID-19] matters ... We've got students coming back to the city, obviously, it's a university city, and we will, you know, [start] to meet to say how can we bring the students back safely. And certainly, on that level, I've seen how we can work effectively together with public health. So I'm confident that there's a mechanism there that would work [for alcohol licensing] ... I see no reason why it wouldn't.*

*Licensing standards manager, area 30, England*



## Discussion

Public health stakeholders' engagement in alcohol licensing work followed one of three main approaches: 'challenging', 'supportive' or 'collaborative'. Their reports suggest an apparent choice between aiming for longer-term, and potentially more radical, cultural change through licensing policies that take a more assertive approach to containing alcohol availability, or attempting to achieve more immediate impacts through 'fitting in' with local licensing system goals, even if that meant forsaking some public health goals. The choice of approach was shaped by several factors, including the response of licensing stakeholders and constraints in the licensing system common to both England and Scotland.

Our finding that all public health teams in Scotland used a 'challenging' approach (sometimes in combination with a 'collaborative' approach) suggests that the presence of a public health objective in Scotland has been helpful for public health teams' engagement by conferring legitimacy on public health stakeholders and data,<sup>24</sup> as suggested in earlier studies in England.<sup>25,26</sup> The objective appears to partly explain why public health teams in Scotland were more active in making representations or objections to licence applications independent of other stakeholders and more comfortable with a 'challenging' approach to the licensing system. The absence of a public health objective in England may have made some English public health teams less confident about doing so and was probably a factor in some teams being more passive or choosing not to engage with licensing at all. Public health's role in promoting the licensing objectives is not always well understood, which can lead to misunderstanding about the outcomes public health should be seeking, and whether or not the reach of public health involvement should encompass outcomes such as public safety, for example.<sup>27</sup> Some public health teams taking a 'challenging' approach reported opposition from licensing stakeholders, in line with previous research in England and Scotland. For example, Somerville<sup>26</sup> found that some licensing and police stakeholders in England felt that a passive 'supportive' approach for public health was most appropriate, although others felt that public health teams should have an equal role to other responsible authorities,<sup>26</sup> more akin to the situation in Scotland. Fitzgerald *et al.*<sup>19</sup> reported public health perceptions that licensing stakeholders sometimes rejected public health as a goal of licensing, and, as suggested by our findings in the ExILeNS study, prioritised economic development instead.

The use of this 'challenging' approach, with its focus on capping availability and reducing alcohol-related harms in the long term, may have limited impact in current licensing systems, which were not developed to address health-related alcohol harms.<sup>28</sup> In Scotland, the public health objective has been reported as difficult to implement in practice in the traditional structures and practices of alcohol premises licensing, which have historically focused on short-term harms.<sup>10,18</sup> The role of public health in alcohol licensing has been described as ambiguous on this basis, introducing the risk of tension, frustration or disillusionment, which could in turn lead to gradual public health disengagement.<sup>28</sup> Indeed, this approach of focusing on alcohol availability was viewed by some public health stakeholders in our study as unrealistic or unhelpful; these stakeholders instead took a more passive 'supportive' approach.

The 'supportive' approach that some public health stakeholders discussed in our study was also explored by Somerville *et al.*,<sup>16</sup> who found a split in opinion among licensing and police staff. Some felt that public health should have a supportive, more minor role compared with other responsible authorities (e.g. supplying data to assist in the development of representations against licensing applications), whereas others felt that public health should have equality of role (e.g. submitting stand-alone representations against licensing applications). The importance of building relationships with licensing teams was emphasised in previous research in Scotland in which a combative 'them and us' approach was felt unlikely to be effective.<sup>19</sup> The public health stakeholders in this previous study were focused on 'winning hearts and minds' of licensing stakeholders to gradually change the licensing system, supporting a focus on public health goals (such as reducing consumption and health harms) – similar to what public health stakeholders taking a 'challenging' approach described in the present study as building licensing stakeholders' understanding of alcohol-related harms. Also emphasising positive relationships with



licensing stakeholders, this 'hearts and minds' approach differs from the 'collaborating' approach described in this report, in which public health stakeholders joined forces with licensing teams for a shared purpose that did not always include public health goals.

Our findings add new insights, in particular highlighting the ways in which some licensing teams took on a guidance role with public health stakeholders. This sometimes resulted in public health teams supporting the licensing system's current focus on short-term harms/crime instead of the licensing system being influenced to work better for public health – in effect, the opposite of what public health stakeholders taking a 'challenging' approach hoped to achieve. In other cases, both groups of stakeholders collaborated positively to focus on both public health and licensing goals. Overall, our findings beg the question: what difference does the approach taken by public health stakeholders actually make to public health outcomes? Public health teams taking a 'challenging' approach focused on containing alcohol availability are supported by extensive evidence that interventions to restrict the availability of alcohol can reduce consumption and related harms.<sup>9,29–32</sup> By contrast, there is limited evidence and/or mixed or weak support for the effectiveness of responsible retailing approaches (such as server training or educational initiatives in premises).<sup>32</sup> The licensing system has been described as legitimately rejecting this academic evidence base in favour of 'native wisdom',<sup>28</sup> to the frustration of public health stakeholders who reported that licensing board members were more interested in 'anecdote'. This clash of cultures of evidence was also highlighted by Somerville *et al.*<sup>16</sup>

Closer examination of the evidence yields a more nuanced understanding. Most studies of alcohol availability have focused on reduced consumption and related acute harms in the short term, with few studies looking at impacts on the longer-term harms on which some public health stakeholders focused.<sup>9</sup> Increased alcohol availability across the UK is likely to partly explain the rise in alcohol-related mortality during the 1990s, alongside greater alcohol affordability.<sup>33</sup> However, the extent to which controlling availability leads to longer-term culture change and reduces consumption and longer-term harms remains unclear. Even the most successful public health efforts in influencing licensing could only prevent new licences being granted (i.e. cap availability), because existing licences cannot be revoked on overprovision/cumulative impact grounds. Although culture can be shaped by policy over time, the physical availability of alcohol in the UK is high relative to other countries;<sup>34</sup> therefore, capping availability may not yield the benefits implied by other studies. Furthermore, the licensing system is ill-equipped to consider or control increasing online availability.

In this context, it is unclear the extent to which public health action can, or ever could, make a significant difference to longer-term health outcomes through efforts to contain licence numbers. Still, preventing further rises in availability may halt the normalisation of alcohol in everyday life, and it may have a role to play in reducing harms as part of a package of wider policy measures, most of which are not under local control.<sup>19</sup> Further limitations in the evidence around the role of online availability,<sup>35,36</sup> availability relative to a person's place of work or daily travel, and interactions between availability and price<sup>9</sup> may also give rise to expanded areas of focus for public health efforts. It may well be that the impact of public health stakeholders on the licensing system will take a long time to emerge, and/or that demonstrably unsuccessful public health efforts will lead to improvements in the licensing system, especially where a public health objective has been set for licensing but is not being achieved. Recent studies in diverse high-income cities<sup>37,38</sup> also suggest that restrictions on temporal availability, particularly after midnight, may also be very effective in reducing short-term alcohol harms from on-trade premises; this may work even where physical availability is high, but was rarely a focus of public health stakeholders in this study.

As we emerge from the COVID-19 crisis in the UK, a key challenge for public health stakeholders and their partners in local government is how, or if, support for local economies can be achieved without deprioritising public health. Intensive lobbying and sympathy for local bars and clubs as they look to recover from the restrictions applied during the pandemic, and potential fatigue with public health influence on everyday life, may also make the job of public health stakeholders in alcohol licensing even harder. It would be wrong to suggest, however, that an approach compatible with improving public



health requires a trade-off in economic success. In Queensland, Australia, targeted restrictions on the late-night supply of alcohol through reduced trading hours were found to reduce numbers of hospital admissions, serious assaults and other forms of violence and injury, and, critically, with no measurable negative impacts on the night-time economy.<sup>39</sup> The number of people entering licensed venues and moving through night-time precincts remained stable, and in some areas a greater diversification of entertainment offerings was observed.<sup>40,41</sup> This highlights the importance of documenting impacts beyond assaults and injuries, for example including impacts on nightlife and trade, in future studies.

## Strengths and limitations

These findings were generated from a relatively large data set involving 53 interviewees from diverse areas. The use of lengthy qualitative interviews provided each interviewee with the opportunity to discuss a wide range of issues based on their own understanding of what was important. The inclusion of both public health and other licensing stakeholders in diverse roles was also a strength of the study. The findings will assist public health teams to develop and reflect on the nature of, and rationale for, their approaches to alcohol premises licensing. Our study was also subject to at least three limitations. First, we did not include public health teams that had little or no engagement in alcohol licensing, although we were able to recruit 20 of them for other elements of the ExLEnS study. Their rationale for not engaging may have shed further light on challenges or limitations in this work. Second, some public health interviewees struggled to articulate their rationale for involvement in alcohol premises licensing at the time of interview; interview topics could be provided to interviewees in advance to overcome this limitation in future studies. Third, our sampling fraction was much higher in Scotland than in England given the number of participating areas. This may reflect higher levels of public health activity in licensing in Scotland. However, all 20 areas recruited are represented in our data and our data were analysed at a team level rather than at an individual level. It is also worth noting that differing structures and systems of public health and licensing in Scotland and England had some bearing on public health actions. Measurement of public health activity in all participating local authorities using a new composite measure, allowing comparison between Scotland and England and exploration of the influence of system differences in more detail, is reported in a forthcoming publication.<sup>23</sup>

## Areas for future research

There are several avenues for future research arising. First, it would be valuable to investigate whether or not differing public health approaches (including 'challenging', 'supportive' and 'collaborative' approaches) make a difference to outcomes, including crime and health outcomes, over the longer term, to inform public health practice. Second, case study research could further explore innovative approaches or perceived successes in public health engagement in alcohol licensing, and encourage peer learning across areas. Third, improved theorisation of how changes in local availability might have an impact on harms is needed, translating international evidence into a plausible story of how such changes might work in a local area. It seems likely that assumptions being made here may underpin engagement and decision-making on public health issues. We have explored public health and licensing stakeholders' views on this, reported separately in a forthcoming publication; however, further exploration with experts would also be helpful. Finally, further work is needed to better understand the impact of shifts to online purchasing, and of changing behaviours arising from the pandemic, on the link between alcohol availability and harms. This will have important implications for the future focus of public health efforts.



## Conclusions

In engaging with alcohol licensing, some public health stakeholders sought to challenge the licensing system, with the aim of containing alcohol availability, although this was found to be difficult to achieve. Others took a passive role, supporting the functioning of the licensing system when asked; by default this meant supporting a more traditional focus on retail practices and short-term harms/crime. A third public health approach also focused on these traditional outcomes and involved close partnership working with the licensing team, sometimes retaining a parallel focus on availability. These qualitative findings provide an in-depth, contextualised understanding of different public health roles in alcohol licensing. They are drawn from a large and diverse sample, but may not be generalisable to all public health and licensing teams. In addition, sampling did not include lower-activity areas, in which experiences might differ. The extent to which current licensing systems enable achievement of public health goals is questionable; the effectiveness of public health efforts in terms of impact on outcomes merits quantitative evaluation.



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These analyses were part of the larger ExILEnS project and all authors contributed to the design of the study.

## Publications

O'Donnell R, Mohan A, Purves R, Maani N, Egan M, Fitzgerald F. Navigating different public health roles in alcohol premises licensing: a multi-stakeholder interview study. *Lancet* 2021;**398**(S14).

Nicholls J, O'Donnell R, Mahon L, Fitzgerald N, on behalf of the ExILEnS Consortium. 'Give us the real tools to do our jobs': views of UK stakeholders on the role of a public health objective for alcohol licensing. *Public Health* 2022; in press.

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

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# References

1. Ritchie H, Roser M. *Alcohol Consumption*. 2018. URL: <https://ourworldindata.org/alcohol-consumption> (accessed 7 October 2021).
2. Great Britain. *Licensing Act 2003*. London: The Stationery Office; 2003. URL: [www.legislation.gov.uk/ukpga/2003/17](http://www.legislation.gov.uk/ukpga/2003/17) (accessed 14 February 2022).
3. Scottish Parliament. *Licensing (Scotland) Act 2005*. London: The Stationery Office; 2005. URL: [www.legislation.gov.uk/asp/2005/16](http://www.legislation.gov.uk/asp/2005/16) (accessed 14 February 2022).
4. Popova S, Giesbrecht N, Bekmuradov D, Patra J. Hours and days of sale and density of alcohol outlets: impacts on alcohol consumption and damage: a systematic review. *Alcohol* 2009;**44**:500–16. <https://doi.org/10.1093/alcalc/agn054>
5. Wilkinson C, Livingston M, Room R. Impacts of changes to trading hours of liquor licences on alcohol-related harm: a systematic review 2005–2015. *Public Health Res Pract* 2016;**26**:e2641644. <https://doi.org/10.17061/phrp2641644>
6. Coke C, Murage P, Smolar M, Tong M. *Licensing Information Pack Resources to Inform Local Action on Alcohol Misuse*. London: London Health Improvement Board; 2014.
7. Alcohol Focus Scotland. *Licensing Resource Pack*. Glasgow: Alcohol Focus Scotland; 2017. URL: [www.alcohol-focus-scotland.org.uk/media/291077/afs-licensing-resource-pack.pdf](http://www.alcohol-focus-scotland.org.uk/media/291077/afs-licensing-resource-pack.pdf) (accessed 29 April 2022).
8. Foster J, Charalambides L. *The Licensing Act (2003): Its Uses and Abuses 10 Years On*. London: Institute of Alcohol Studies; 2016.
9. Holmes J, Guo Y, Maheswaran R, Nicholls J, Meier PS, Brennan A. The impact of spatial and temporal availability of alcohol on its consumption and related harms: a critical review in the context of UK licensing policies. *Drug Alcohol Rev* 2014;**33**:515–25. <https://doi.org/10.1111/dar.12191>
10. Fitzgerald N, Winterbottom J, Nicholls J. Democracy and power in alcohol premises licensing: a qualitative interview study of the Scottish public health objective. *Drug Alcohol Rev* 2018;**37**:607–15. <https://doi.org/10.1111/dar.12819>
11. Great Britain. *Health and Safety at Work etc. Act 1974*. London: The Stationery Office; 1974.
12. de Vocht F, Heron J, Angus C, Brennan A, Mooney J, Lock K, et al. Measurable effects of local alcohol licensing policies on population health in England. *J Epidemiol Community Health* 2016;**70**:231–7. <https://doi.org/10.1136/jech-2015-206040>
13. De Vocht F, Heron J, Campbell R, Egan M, Mooney JD, Angus C, et al. Testing the impact of local alcohol licensing policies on reported crime rates in England. *J Epidemiol Community Health* 2017;**71**:137–45. <https://doi.org/10.1136/jech-2016-207753>
14. Reynolds J, McGrath M, Engen J, Pashmi G, Andrews M, Lim J, Lock K. Processes, practices and influence: a mixed methods study of public health contributions to alcohol licensing in local government. *BMC Public Health* 2018;**18**:1385. <https://doi.org/10.1186/s12889-018-6306-8>
15. Reynolds J, McGrath M, Engen J, Pashmi G, Andrews M, Egan M, et al. *Strengthening Public Health Contributions to Alcohol Licensing Processes: Findings from the Public Health and Alcohol Licensing (PHAL) Study*. London: London School of Hygiene & Tropical Medicine; 2018. URL: <https://sphr.lshtm.ac.uk/files/2018/06/PHAL-study-final-report-12-06-18.pdf> (accessed 14 February 2022).

16. Somerville L, Thom B, Herring R. Public health participation in alcohol licensing decisions in England: the importance of navigating 'contested space'. *Drugs Alcohol Today* 2020;**20**:323–35. <https://doi.org/10.1108/DAT-05-2020-0025>
17. Mooney JD, Holmes J, Gavens L, de Vocht F, Hickman M, Lock K, Brennan A. Investigating local policy drivers for alcohol harm prevention: a comparative case study of two local authorities in England. *BMC Public Health* 2017;**17**:825. <https://doi.org/10.1186/s12889-017-4841-3>
18. MacGregor A, Sharp C, Mabelis J, Corbett J. *An Evaluation of the Implementation of, and Compliance With, the Objectives of the Licensing (Scotland) Act 2005: Final Report*. Edinburgh: NHS Health Scotland; 2013.
19. Fitzgerald N, Nicholls J, Winterbottom J, Katikireddi SV. Implementing a public health objective for alcohol premises licensing in Scotland: a qualitative study of strategies, values, and perceptions of evidence. *Int J Environ Res Public Health* 2017;**14**:E221. <https://doi.org/10.3390/ijerph14030221>
20. Fitzgerald N, Egan M, de Vocht F, Angus C, Nicholls J, Shortt N, *et al*. Exploring the impact of public health teams on alcohol premises licensing in England and Scotland (ExILEnS): protocol for a mixed methods natural experiment evaluation. *BMC Med Res Methodol* 2018;**18**:123. <https://doi.org/10.1186/s12874-018-0573-z>
21. Home Office. *Local Alcohol Action Areas*. 2014. URL: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/278742/LAAAs.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/278742/LAAAs.pdf) (accessed 15 February 2022).
22. Home Office. *Local Alcohol Action Areas Will Tackle Alcohol Related Harms*. URL: [www.gov.uk/government/news/local-alcohol-action-areas-will-tackle-alcohol-related-harms](http://www.gov.uk/government/news/local-alcohol-action-areas-will-tackle-alcohol-related-harms) (accessed 15 February 2022).
23. Fitzgerald N, Mohan A, Purves R, O'Donnell R, Egan M, Nicholls J, *et al*. How do legal, structural and philosophical differences influence public health team engagement in alcohol premises licensing in England and Scotland? Interview and documentation analysis. *Public Health Res* 2022; in press.
24. Nicholls J, O'Donnell R, Mahon L, Fitzgerald N, on behalf of the ExILEnS Consortium. 'Give us the real tools to do our jobs': views of UK stakeholders on the role of a public health objective for alcohol licensing. *Public Health* 2022; in press.
25. Reynolds J, McGrath M, Engen J, Pashmi G, Andrews M, Sharpe C, *et al*. 'A true partner around the table?' Perceptions of how to strengthen public health's contributions to the alcohol licensing process. *J Public Health* 2019;**41**:e1–e8. <https://doi.org/10.1093/pubmed/fdy093>
26. Somerville L. *Public Health Involvement in Alcohol Licensing Decisions: Policy, Partnerships and Professional Ideology*. PhD thesis. London: Middlesex University London; 2018.
27. Public Health England. *Findings from the Pilot of the Analytical Support Package for Alcohol Licensing*. London: Public Health England; 2017. URL: [www.gov.uk/government/publications/alcohol-licensing-pilot-of-analytical-support-package/findings-from-the-pilot-of-the-analytical-support-package-for-alcohol-licensing](http://www.gov.uk/government/publications/alcohol-licensing-pilot-of-analytical-support-package/findings-from-the-pilot-of-the-analytical-support-package-for-alcohol-licensing) (accessed 29 April 2022).
28. Nicholls J. Public health and alcohol licensing in the UK: challenges, opportunities, and implications for policy and practice. *Contemp Drug Prob* 2015;**42**:27–105. <https://doi.org/10.1177/0091450915579875>
29. Bryden A, Roberts B, McKee M, Petticrew M. A systematic review of the influence on alcohol use of community level availability and marketing of alcohol. *Health Place* 2012;**18**:349–57. <https://doi.org/10.1016/j.healthplace.2011.11.003>



30. Sherk A, Stockwell T, Chikritzhs T, Andréasson S, Angus C, Gripenberg J, *et al.* Alcohol consumption and the physical availability of take-away alcohol: systematic reviews and meta-analyses of the days and hours of sale and outlet density. *J Stud Alcohol Drugs* 2018;**79**:58–67. <https://doi.org/10.15288/jsad.2018.79.58>
31. Middleton JC, Hahn RA, Kuzara JL, Elder R, Brewer R, Chattopadhyay S, *et al.* Effectiveness of policies maintaining or restricting days of alcohol sales on excessive alcohol consumption and related harms. *Am J Prev Med* 2010;**39**:575–89. <https://doi.org/10.1016/j.amepre.2010.09.015>
32. Martineau F, Tyner E, Lorenc T, Petticrew M, Lock K. Population-level interventions to reduce alcohol-related harm: an overview of systematic reviews. *Prev Med* 2013;**57**:278–96. <https://doi.org/10.1016/j.ypmed.2013.06.019>
33. McCartney G, Bouttell J, Craig N, Craig P, Graham L, Lakha F, *et al.* Explaining trends in alcohol-related harms in Scotland 1991–2011 (II): policy, social norms, the alcohol market, clinical changes and a synthesis. *Public Health* 2016;**132**:24–32. <https://doi.org/10.1016/j.puhe.2015.12.012>
34. Angus C. *The Changing Face of Alcohol Availability in Great Britain: An Analysis of Trends in Outlet Types and Density Between 2003–2014*. Presented at the 41st Annual Alcohol Epidemiology Symposium of the Kettil Bruun Society, Munich, Germany, 1–5 June 2015.
35. Callinan S, MacLean S. COVID-19 makes a stronger research focus on home drinking more important than ever. *Drug Alcohol Rev* 2020;**39**:613–15. <https://doi.org/10.1111/dar.13125>
36. Colbert S, Wilkinson C, Thornton L, Feng X, Richmond R. Online alcohol sales and home delivery: an international policy review and systematic literature review. *Health Policy* 2021;**125**:1222–37. <https://doi.org/10.1016/j.healthpol.2021.07.005>
37. de Goeij MC, Veldhuizen EM, Buster MC, Kunst AE. The impact of extended closing times of alcohol outlets on alcohol-related injuries in the nightlife areas of Amsterdam: a controlled before-and-after evaluation. *Addiction* 2015;**110**:955–64. <https://doi.org/10.1111/add.12886>
38. Rossow I, Norström T. The impact of small changes in bar closing hours on violence. The Norwegian experience from 18 cities. *Addiction* 2012;**107**:530–7. <https://doi.org/10.1111/j.1360-0443.2011.03643.x>
39. Coomber K, de Andrade D, Puljević C, Ferris J, Livingston M, Taylor N, *et al.* The impact of liquor legislation changes on police-recorded serious assault in Queensland, Australia [published online ahead of print 20 May 2021]. *Drug Alcohol Rev* 2021. <https://doi.org/10.1111/dar.13181>
40. Ferris J, Puljević C, Taylor N, de Andrade D, Carah N, Coomber K, *et al.* The impact of Queensland's tackling alcohol-fuelled violence policy on nightlife and business trade [published online ahead of print 20 May 2021]. *Drug Alcohol Rev* 2021. <https://doi.org/10.1111/dar.13271>
41. Miller PG, Coomber K, de Andrade D, Livingston M, Puljević C, Vakidis T, *et al.* Summarising the impacts of the Queensland Alcohol-related violence and Night-Time Economy (QUANTEM) project. *Drug Alcohol Rev* 2021;**40**:755–60. <https://doi.org/10.1111/dar.13272>

