



# Using licensing to protect public health

From evidence to practice

August 2014

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# EXECUTIVE SUMMARY

## Background

International evidence clearly indicates that increasing the price and reducing the availability of alcohol are amongst the most effective policy measures to reduce alcohol consumption and harm in a population. Licensing is the mechanism by which the availability of alcohol is regulated in the UK, controlling numbers and types of alcohol outlets, opening hours and conditions of sale. In recent years there has been policy divergence between Scotland and England with regards to licensing legislation. Scotland is working towards a population-based approach to alcohol policy development while policymaking in England and Wales continues to emphasise market autonomy and voluntary partnerships with industry. In licensing legislation, two of the main differences between Scotland and England is the inclusion of a fifth licensing objective in Scottish legislation – to protect and improve public health – and the requirement for licensing boards to assess the overprovision of licenced premises in the board's area and to include a statement on overprovision in the statement of licensing policy.

These elements of Scottish licensing legislation would appear to position Scotland favourably with regards to addressing changing drinking behaviours, in particular the increasingly dominant role of off-sales in shaping consumption patterns. However, licensing has historically tended to focus on the prevention of antisocial behaviour rather than the protection of health and its key instruments were developed to regulate public drinking in pubs, clubs and bars rather than address the challenges of a market in which the off-trade is a significant factor. Furthermore, licensing board members often appear to struggle to apply scientific evidence to policy and decision-making in practice. There are also challenges in effectively merging the perspectives and practices of licensing and public health: public health considerations tend to concern population-level indicators and long-term trends, whereas licensing operates in an environment characterised by case-by-case decision-making, negotiated settlements and complex legal argument.

Scottish licensing legislation provides an opportunity to reaffirm the public interest purpose of the licensing system but gaps in knowledge and understanding among the key stakeholders, as well as differences of practice and perspective, can act as barriers to the full realisation of the potential of the licensing system to reduce alcohol-related harm.

The objectives of this study were:

1. To build capacity within licensing boards in Scotland to enable them to give meaningful effect to the licensing objective "to protect and improve public health" (which is unique to Scotland);
2. To foster closer working relationships and greater understanding between licensing personnel and public health practitioners; to increase awareness of the evidence linking alcohol availability and harm; and help them understand one another's role in the licensing process;
3. To share knowledge and learning with key licensing stakeholders across the UK on the potential of licensing to contribute to the reduction of alcohol harms.

## Methods

There were three core elements to the work involved in the study:

1. Increased dialogue and understanding between licensing personnel and public health practitioners in Scotland by holding a series of **regional licensing events**.
2. Development and dissemination of a **resource toolkit** for licensing personnel in Scotland.
3. Knowledge transfer with licensing and public health personnel in Scotland, England, Wales and Northern Ireland through **dialogue** sessions for a range of licensing and public health stakeholders.

The regional licensing events were held in six locations across Scotland and brought licensing officials and public health representatives together to explore and discuss the potential of the licensing system to promote and improve public health. Information on participants' responses to proposed approaches to shaping licensing policy and decision-making was gathered at the events which was used to inform subsequent work.

A resource toolkit on licensing policy development was produced and disseminated to over 700 licensing and public health contacts across Scotland to assist with the process of gathering evidence and developing statements of licensing policy in 2013. The toolkit comprised four sections relating to different aspects of licensing policy development. Publication was staggered during 2012/13 to coincide with the timescales being followed by licensing boards.

A dialogue group was established comprising representatives from public health organisations from Scotland and England. During a series of meetings between 2012 and 2013 the group considered lessons that could be learned from Scotland in the context of public health becoming a 'responsible authority' for licensing under the 2011 Police Reform and Social Responsibility Act in England. The group provided a platform for sharing information and ideas on public health and licensing which were communicated to over 800 stakeholders across Scotland and England via a series of conference and events that group members contributed to.

## Results

- The regional events held in Scotland in early 2012 achieved high levels of attendance and provided an opportunity for collective consideration of licensing policy and decision-making in the context of evidence of health harms associated with the availability of alcohol.
- Participants at the events recorded high levels of understanding of the shift in alcohol purchase patterns to a predominance of off-sales and the need for licensing to regulate off-sales as well as on-sales.

- However, confidence in the ability to gather, analyse and interpret the necessary information, including health data to inform effective regulation, was relatively low, suggesting the need for support.
- The licensing resource toolkit produced following the regional events provided a reference point and guide for licensing officials in the preparation of statements of licensing policy in 2013. It was also used by public health representatives to guide evidence-gathering for licensing boards based on levels of health harm along with other information and evidence.
- The UK dialogue group enabled the dissemination of information about the Scottish experience of public health engagement in licensing across England, helping to clarify a number of challenges for both health and licensing teams in England in establishing closer working relationships. This work is continuing as part of the Public Health England Licensing and Public Health Network.
- Evidence gathered during the project suggests that public health partners have increased engagement and participation in the licensing process in Scotland.
- With regards to the impact of this increased engagement, Scottish statements of licensing policy in 2013 show an increased use of health evidence in comparison to the previous statements published in 2010. Nine percent of policies in 2010 cited the use of health evidence in comparison with thirty-six percent in 2013.
- Ten licensing boards in Scotland have declared overprovision in 2013 in comparison with seven in 2010. Five have declared overprovision across a wide geographical area in 2013 in comparison with just one in 2010, better equipping them to address control the overall availability of alcohol in the board area.
- The progress suggests that increased engagement with public health has increased awareness among some licensing officials of the relationships between alcohol availability, consumption and harm, and increased their confidence to use overprovision policies as a mechanism to regulate outlet density.
- In the two case study areas, increased awareness of health evidence and the potential for overprovision to contribute to measures to reduce harm is attributed to the involvement of public health partners. However, interviewees in only one of the two case study areas were unanimously satisfied with the resulting licensing policy.
- Some licensing stakeholders that participated in the telephone interviews in the second case study area, expressed frustration that despite a perceived improvement in engagement, consultation and provision of evidence, the licensing board had not acted upon the information received. This was with particular reference to the evidence provided by police and health representatives.
- In the same case study area interviewees reported that the concept of overprovision was still contested and often misunderstood.
- While progress with regards to promoting the public health objective has been made in some licensing board areas, there are still a minority of licensing policy statements from across Scotland which demonstrate the general evidence base

for the policy approach. Less than half of the policy statements produced in 2013 demonstrate or reference the health evidence that has been used to reach the policy position.

- Only just over one quarter of licensing policy statements include a policy on overprovision in any part of the licensing board area.

## Conclusions

While impact has been demonstrated with regards to increased engagement of public health in the licensing process, the evaluation has shown that overall, the extent to which health data is used in practice continues to be subject to varying interpretations of the evidence by licensing board members and officials. The licensing policy outcome therefore does not always reflect the health evidence presented.

But whilst the licensing policy outcome does not always reflect the health evidence presented, progress has been made with regards to strengthening the working relationships between public health and licensing stakeholders in Scotland. Signs of increased capacity in licensing boards to give more meaningful effect to the licensing objective 'to protect and improve public health' are evidenced by the increased use of health evidence in licensing policy development and in some published positions on the overprovision of licensed premises. However, when considering the published statements of licensing policy in 2013 as a whole, progress has been relatively limited. Further work is needed to scrutinise licensing decisions in the context of the 2013 statements of policy in order to assess the impact of policy positions. Public health partners should continue to promote the use of health evidence to support licensing decision-making.

The project has involved significant regional work to further understanding and increase dialogue between licensing and public health personnel across the UK. The establishment of the UK dialogue group has enabled the sharing of information, learning and experience providing partners with support and a reference point for their efforts.

In England, the Westminster Government, while acknowledging the international evidence showing that controls on outlet density reduced a range of alcohol-related problems including health harm, concluded that there was not sufficient local data gathering or processes in place to support the implementation of a licensing objective on health. Instead, the government has opted to support the development of local work to improve local evidence which may support the creation of health as a licensing objective in the future.

In Scotland, where protecting and improving public health is a licensing objective enshrined in legislation, there are still obstacles and barriers to this objective being promoted effectively. The work of the project in Scotland has contributed to overcoming some of these barriers by facilitating better relationships and increasing understanding between public health and licensing stakeholders. However, it is clear that more work is needed to make a real and significant impact on alcohol availability and levels of harm.

Given the continued divergence of licensing policy between Scotland and England, it will be important to continue dialogue in order to build capacity to promote and support using licensing to protect public health.



## Background

Alcohol consumption in the UK has been steadily rising over the last sixty years increasing from 5.7 litres per capita (16+) in 1960 to 10.9 litres in 2012 (Beeston et al. 2013). Although consumption has been declining in recent years, alcohol-related harm is still at record levels. The UK has gone from having one of the lowest liver cirrhosis mortality rates in Western Europe to having one of the highest. In Scotland, alcohol consumption is higher than in the rest of the UK with recent research indicating that an additional 1.7 litres of pure alcohol were sold per adult in Scotland in 2012 (10.9L) compared to England and Wales (9.2L), a difference of 19% (Robinson and Beeston, 2013). A growing knowledge of the role of alcohol in a wide range of acute and chronic disorders, and a greater understanding of its negative social impacts, has increased the demand for licensing to regulate availability in a way that addresses the full spectrum of alcohol-related harm. Overall, the weight of international evidence indicates that increases in the supply of alcohol through more outlets and longer trading hours, influences a range of alcohol-related harms and sometimes levels and patterns of consumption (MacNaughton and Gillan, 2011; Popova et al. 2009; Campbell et al, 2009).

International evidence clearly indicates that increasing the price and reducing the availability of alcohol are amongst the most effective policy measures to reduce alcohol consumption and harm in a population (Babor et al, 2010). Licensing is the mechanism by which the availability of alcohol is regulated in the UK, controlling numbers and types of alcohol outlets, opening hours and conditions of sale. Licensing developed out of a need to limit harms associated with alcohol by empowering local authorities to approve those eligible for a licence, to withdraw licences where necessary and to place conditions on the management of licensed premises (Webb and Webb, 1963). In other words, licensing exists because alcohol is not an ordinary commodity and one of its primary roles is to manage the retail provision of alcohol in such a way as to mitigate the risks of harm associated with its consumption.

In recent years there has been policy divergence between Scotland and England with regards to licensing legislation (Nicholls, 2012). The 2003 Licensing Act (England and Wales) and the 2005 Licensing Act (Scotland) differ in a number of key respects. The Scottish Act includes the same four licensing objectives contained in the English Act: preventing crime and disorder; securing public safety; preventing public nuisance and protecting children from harm. However, there is a fifth licensing objective which is unique to Scotland – 'to protect and improve public health'. In addition, the Scottish Act requires licensing boards to have a policy on the 'overprovision' of licensed premises; establishes licensing standards officers and local licensing forums; gives the public a right to object to licence applications and contains a mandatory condition on irresponsible promotions. The 2010 Alcohol Etc. (Scotland) Act and the 2012 Alcohol Minimum Pricing (Scotland) Act represent further divergence in policy and practice with the introduction of measures including a ban on quantity discounts, restrictions on alcohol display and promotion in off-sales and the introduction of a minimum price per unit of alcohol<sup>1</sup>. The Coalition Government at Westminster has announced controls on selling alcohol below the cost of duty and VAT and has included additional provisions

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<sup>1</sup> The Scottish Government has set the price per unit of alcohol at 50p but the implementation of minimum unit pricing legislation has been delayed by legal action by trade bodies representing alcohol producers. On 30 April 2014 the case was referred to the Court of Justice of the European Union by the Scottish Court of Session.

(specifically Early Morning Restriction Orders and the Late Night Levy) through the Police Reform and Social Responsibility Act 2011; nevertheless, the law in Scotland goes far beyond current legislation in England and Wales in regard to regulating the retail market. In recent years Scotland worked towards adopting a population-based approach to alcohol policy development which provides the impetus and context for the use of licensing legislation as a contributory measure to manage the availability of alcohol. Policy making in England and Wales on the other hand continues to emphasise market autonomy and voluntary partnerships with industry.

These developments mean that Scottish licensing law represents a radical departure from established practice and would appear to position Scotland favourably with regards to addressing changing drinking behaviours, in particular the increasingly dominant role of off-sales in shaping consumption patterns. However, licensing has historically tended to focus on the prevention of antisocial behaviour rather than the protection of health and its key instruments were developed to regulate public drinking in pubs, clubs and bars rather than address the challenges of a market in which the off-trade is a significant factor. Furthermore, licensing board members in Scotland often appear to struggle to apply the scientific evidence to policy and decision-making in practice. Finally, there are challenges in effectively merging the perspectives and practices of licensing and public health: public health considerations tend to concern population-level indicators and long-term trends established through aggregate datasets, whereas licensing operates in an environment characterised by case-by-case decision-making, negotiated settlements and complex legal argument.

The 2005 Licensing Act requires boards to seek to ensure that licensing policy promotes the licensing objectives. Licensing boards have to demonstrate that they have gathered relevant data to support licensing decisions. As boards are new to the process of systematically collecting health data, interpreting it and then developing a policy position based on evidence, many of the last policy statements produced in 2010 did not cite health evidence in support of their policy. Scottish licensing legislation provides an opportunity to reaffirm the public interest purpose of the licensing system but gaps in knowledge and understanding among the key stakeholders, as well as differences of practice and perspective, can act as a barrier to the full realisation of the potential of the licensing system to reduce alcohol-related harm.

In response to this issue, in June 2011 AFS and Scottish Health Action on Alcohol Problems (SHAAP) convened an expert group on public health and licensing which was attended by international experts, to consider how licensing personnel and public health practitioners could collaborate more effectively to support licensing decision-making in the public health interest. As part of the process, Senior Counsel was commissioned to provide legal opinion on the practical implementation of the public health objective within the Licensing (Scotland) Act 2005. In summary, the opinion noted that the Act required licensing boards to obtain sufficient information to enable them to 'ensure' that licensing policies promote the licensing objectives. It further noted that the most obvious control for protecting and improving public health lay in the policy on overprovision but can also be wider, taking account of the impact of licensed hours and other factors. Finally, the opinion noted that policies had to be founded on a sound factual basis and fall within the legal parameters of the Act, therefore the promotion of the health objective must be linked to the effects of the sale of alcohol. The opinion acknowledged that it is difficult for a board to promote the health objective in relation to any individual licence application because it is difficult to

evidence ill effects on health at individual premises level, because the evidence is generally at population or board area level. However, an individual application could be refused if it was shown to be contrary to a board's statement of licensing policy, where the policy is formulated on the basis of wider evidence. In other words, the legislation provides for the practical implementation of the objective to protect and improve public health but arguably, effective implementation requires licensing boards to take a new or updated approach to gathering, analysing and interpreting evidence to inform their licensing policy. This has implications for licensing personnel with regards to knowledge and understanding, but also for public health practitioners in the presentation of evidence and arguments to inform licensing decision-making.

The report of the findings from the expert group *Re-thinking Alcohol Licensing* was published in September 2011 containing twenty recommendations for licensing boards, local authorities and the Scottish Government with the aim of improving support and guidance to licensing stakeholders on how to promote the public health objective.

## Aims of the Project

Following publication of *Re-thinking Alcohol Licensing*, funding was secured from Alcohol Research UK to carry out an 18-month programme of work to promote better links between licensing and public health. The programme had three key aims:

1. To build capacity within licensing boards in Scotland to enable them to give meaningful effect to the licensing objective "to protect and improve public health" (which is unique to Scotland);
2. To foster closer working relationships and greater understanding between licensing personnel and public health practitioners; to increase awareness of the evidence linking alcohol availability and harm; and help them understand one another's role in the licensing process;
3. To share knowledge and learning with key licensing stakeholders across the UK on the potential of licensing to contribute to the reduction of alcohol harms.

To realise the aims of the project, three core elements of a work programme were identified:

1. Increased dialogue and understanding between licensing personnel and public health practitioners in Scotland by holding a series of regional licensing events.
2. Development and dissemination of a resource toolkit for licensing personnel in Scotland.
3. Knowledge transfer with licensing and public health personnel in Scotland, England, Wales and Northern Ireland through dialogue sessions for a range of licensing and public health stakeholders.

## Increased dialogue and understanding between licensing personnel and public health practitioners

Six regional events were held at locations across Scotland between 23 January and 2 March 2012. The two key aims were to:

- Foster closer working relationships and greater understanding between licensing personnel and public health practitioners
- Take the recommendations in *Re-thinking Alcohol Licensing* to local audiences to explore local experience and reaction to the recommendations.

Involvement of local partners in the planning and delivery of the events was prioritised to ensure buy-in and encourage attendance and to reflect recent local experiences of the licensing process. For example, Alcohol and Drug Partnerships (ADPs) in the Grampian region reported struggling to engage with licensing boards in their locality. Making the events more locally focused was advantageous as they capitalised on existing knowledge, experience, links and relationships.

The key target groups for the events were: licensing boards (members and legal advisors); local licensing forums (members and legal advisors); ADP officials; and health board personnel with a remit for licensing. It was also recognised that it would be useful to involve licensing standards officers and police with a licensing remit. Tailored invitations were sent to local representatives of these groups. A total of 261 participants attended the events.

Tables 1 and 2: Attendees by region and stakeholder group

| Event/Region                | Attendance |
|-----------------------------|------------|
| Aberdeen/north east         | 78         |
| Edinburgh/central belt east | 36         |
| Inverness/north west        | 31         |
| Glasgow/central belt west   | 60         |
| Perth/central               | 30         |
| Kirkcudbright/south west    | 26         |

| Stakeholder Group                      | Attendance                             |
|--|--|
| Licensing Board Members                | 50 (representing 24 Licensing Boards)  |
| Licensing Forum Members                | 53 (representing 24 Licensing Forums)  |
| Licensing Legal Advisors               | 39                                     |
| Alcohol & Drug Partnerships            | 21 (representing 15 ADPs)              |
| Directors/Consultants of Public Health | 30 (representing 8 NHS Boards)         |
| Licensing Standards Officers           | 20 (representing 14 Local Authorities) |
| Police Scotland                        | 28 (representing 7 Police Forces)      |
| Other Local Authority representatives  | 15 (representing 5 Local Authorities)  |
| Community Members                      | 5                                      |

The high levels of attendance and diversity of the stakeholders represented demonstrated the growing recognition across Scotland of the importance of managing the availability of alcohol as a public health concern, and the role that licensing has in this.

The regional events consisted of a two hour programme during which AFS summarised the findings and recommendations of *Re-thinking Alcohol Licensing*, and local public health experts provided evidence of alcohol harm in the region. Votes were taken on four key questions to enable the gathering of data on attitudes towards and perceptions of the public health objective across the country.

The four questions on which participants could record their 'yes' or 'no' answers were:

1. *Do you agree that Licensing Boards should prioritise formulating a comprehensive, evidence-based statement of licensing policy?*

There was support at all events for the need for evidence-based policies, with those voting 'yes' ranged from 92% - 100%. Where people did not agree or abstained, comments recorded indicated that this was due to concern about the ability to define and obtain sufficient evidence.

2. *Do you agree that licensing policy should take into account the aggregate/overall effect of licensed premises on drinking behaviour and levels of alcohol harm in their local population?*

Answers to this question showed some variation between different areas of the country. At the northern events in Aberdeen and Inverness less than half of participants (48%) agreed in comparison with events in central and southern Scotland where support ranged from 89 – 99% of participants. Comments at the northern events in Aberdeen and Inverness suggest that uncertainty was due to concerns about how this approach could be applied in practice across areas with both urban and rural populations.

3. *Do you agree that Licensing Boards and Forums should look at all the evidence before trying to identify 'problem' localities?*

Answers to this question followed a very similar pattern to those for question 2. Stakeholders in areas with a more rural population tended to show less confidence in the ability to gather and analyse relevant and appropriate data and evidence to inform the licensing policy.

4. *Given the distances people travel to buy alcohol, do you agree that Licensing Boards and Forums should look at overprovision over larger areas?*

Similarly to questions 2 and 3, stakeholders in more rural areas of the country indicated less confidence in their ability to identify the appropriate evidence to enable them to consider the potential overprovision of alcohol outlets over larger geographical areas.

The information gathered at the regional events was used to inform the planning and design of the licensing toolkit and further work that was undertaken.

## Development and dissemination of a resource toolkit

### *Statements of Licensing Policy*

Licensing boards in Scotland are required under the 2005 Licensing Act to produce a statement of licensing policy every three years. The statement describes the policy measures a licensing board will implement to promote the licensing objectives in its area. The policy must include a statement on overprovision of licensed premises within its area. The first statements of licensing policy were published by boards in 2007.

### *Licensing resource toolkit*

The Alcohol Focus Scotland licensing toolkit was designed to provide support and guidance to licensing stakeholders in developing evidence-based licensing policies, taking account of the issues identified at the regional events. While there was clear support at the regional events for some of the key ideas in *Re-thinking Alcohol Licensing* uncertainty and a lack of confidence were identified in some parts of the country. Participants agreed that breaking down some of the concepts in *Re-thinking Alcohol Licensing* into a more user-friendly format and providing 'how to' guides would make the information more accessible, promote involvement and provide guidance on the practicalities of applying concepts locally.

Although the participants at the regional events supported the use of evidence to shape licensing policy, a review of the previous licensing policy statements conducted by AFS in 2010 indicated limited use of evidence, particularly concerning health. Further to this, the regional events identified concerns about the practicalities of policy development and implementation.

The toolkit comprised four components to address these issues:

1. *Changing Times: Why we need to change licensing practice.*

This short booklet written in Q&A format looks at trends in alcohol licensing, drinking patterns and problems in Scotland, and how licensing can reduce levels of alcohol harm. It is accompanied by a Licensing Policy Timeline to aid planning and a leaflet providing brief descriptions of the stakeholders involved in the licensing process.

2. *Factsheet 1: Using evidence to support policy and decision making.*

This factsheet explains how licensing boards can make use of different sources of evidence to support policy and decision making and contains a guide to useful sources of evidence.

3. *Factsheet 2: Statements of licensing policy.*

This factsheet covers the main issues licensing stakeholders may wish to consider when drafting a statement of licensing policy. It includes the benefits of licensing policy, the legal basis for using policy to guide licensing decisions, and a suggested template for a policy statement.

4. *Factsheet 3: Developing an effective overprovision policy.*

This factsheet covers the main issues for licensing stakeholders to consider when assessing overprovision of licensed premises and making overprovision decisions. It includes guidance on determining overprovision in practice, the process of preparing an overprovision statement, and the benefits of an effective overprovision policy.

All sections of the toolkit are available on the [Alcohol Focus Scotland website](#).

The publication and dissemination of the toolkit to over 700 contacts in Scotland during 2012/13 was timed to coincide with licensing boards' development of new statements of licensing policy due to be published in November 2013. The toolkit has also been shared with colleagues across the UK as part of the dialogue process discussed later in this report.

*Table 3: Number of toolkits disseminated to stakeholder groups*

| <b>Stakeholder Group</b>              | <b>Number of toolkits disseminated</b> |
|---------------------------------------|--|
| Licensing Boards                      | 350                                    |
| Licensing Forums                      | 200                                    |
| Scottish Government                   | 10                                     |
| Directors of Public Health (DPH)      | 14                                     |
| Consultants in Public Health Medicine | 10                                     |
| NHS Health Scotland & ScotCen         | 3                                      |
| Alcohol and Drug Partnerships         | 150                                    |
| <b>Total</b>                          | <b>737</b>                             |

Researching and writing the toolkit required consultation with a range of alcohol, health, licensing and data experts. This process provided additional opportunities for AFS to influence licensing stakeholders which was not anticipated at the start of the project. For example, it prompted work with the Alcohol Special Interest Group of Consultants in Public Health Medicine. AFS is working with this group to consider the process of collecting, analysing and presenting public health data with the aim of providing tailored support and guidance to health practitioners across Scotland on how best to influence licensing policy and decisions. AFS also worked with national data providers including NHS Health Scotland and Information Services Division (ISD) to ensure that national data on alcohol is relevant and accessible to those working on licensing. In 2013 ISD developed updated alcohol profiles which were published by the Scottish Public Health Observatory (ScotPHO). Profiles are available at health board and ADP level and provide a range of indicators of alcohol harm including four licensing-specific indicators on the rates of alcohol licences per 10,000 of the



population over eighteen years of age. This was the first time the licensing statistics were published as an integral part of alcohol and/or health profiles.

In November 2012, AFS convened a further meeting of experts in public health and licensing to inform the development of the last two sections of the toolkit. In addition to advising on the toolkit, the meeting agreed that further support with the assessment of overprovision could be provided by distributing a case study guide to the process based on the experience of West Dunbartonshire Licensing Board, the only board to declare a large area of their jurisdiction as overprovided in the 2010 statement of licensing policy. Andrew Fraser, former Licensing Board Clerk in West Dunbartonshire is a participant in the expert group and agreed to write a step-by-step guide based on his experience. The guide was published in April 2013 and distributed via the Society of Local Authority Lawyers and Administrators Scotland and via AFS networks to licensing board members, local licensing forums, ADPs and public health representatives, reaching more than 700 contacts.

### *Public consultation on licensing policy*

Licensing boards are required to preface their policy statement with a consultation including among others, the local licensing forum. In practice most boards carry out a public consultation including a range of interested parties and stakeholders including the local licensing forum. The consultation process is not prescribed in legislation or the accompanying guidance and the approaches adopted can vary significantly from board to board. Variation in practice includes communication on the consultation, selection of stakeholders to seek consultation responses from, the format of the consultation itself and the analysis of information received. It is therefore difficult to assess and compare the quality of consultation across the country.

During 2012 and early 2013, AFS responded directly to approximately a quarter of licensing board consultation exercises on draft policy statements. AFS also provided direct support to partners in four areas of Scotland where the licensing forum and ADPs were working together to gather and present evidence to inform the licensing policy statement. The areas were Edinburgh City, Dundee City, West Dunbartonshire and Scottish Borders. This activity provided an opportunity to reinforce the messages and guidance in the toolkit and to respond directly to licensing policy in distinct geographical areas.

### *Knowledge transfer with licensing and public health personnel across the UK*

A dialogue group was established in May 2012, chaired by Dr James Nicholls. The dialogue group comprised of representatives from Alcohol Focus Scotland, the Local Government Association, the London Health Improvement Board, NHS South West, Balance North East, Drinkwise North West, the Institute of Alcohol Studies, and the Alcohol Academy. During a series of meetings between 2012 and 2013 it considered lessons that could be learned from Scotland in the context of public health becoming a 'responsible authority' for licensing under the 2011 Police Reform and Social Responsibility Act.



In 2014 the membership of the dialogue group was expanded and brought under the auspices of Public Health England as a national Licensing and Public Health Network.

A number of challenges to the effective engagement of public health in licensing practice were identified by the dialogue group:

- Availability, accessibility, consistency and interpretation of data which could practically support licensing policy and decision making.
- Lack of locally-specific data linking outlet numbers, types and density to both acute and chronic health impacts. Variable degrees of priority given to alcohol policy among health teams regionally.
- A need for better working communication between licensing and public health teams.
- Limited understanding of licensing processes among health practitioners.
- Limited understanding of health data among licensing practitioners.
- Time and capacity limitations for health teams tasked with reviewing licence applications.
- The opacity of the licensing system and a consequent lack of public engagement with licensing processes
- The lack of a health-oriented licensing objective in primary legislation in England.
- A reactive, rather than strategic, approach to licensing regulation in many areas.
- Difficulties in quantifying long term health costs against shorter-term economic gains
- A need to distinguish between health involvement at the level of individual decisions, and health input into strategic planning – especially the development of local Statements of Licensing Policy
- Resistance to the principle that licensing should promote the reduction of health harms, or adopt a policy-led approach to decision-making

Practical actions taken forward by members of the dialogue group, sometimes in collaboration with other partners, included:

- A [joint briefing](#) produced by the Local Government Association and Alcohol Research UK for Directors of Public Health in England and Wales on their new powers in relation to licensing released in February 2013.
- Contribution to the development of a [data-pack](#) for health teams to support licensing policy and decisions by London Health Improvement Board.
- Development of advocacy training for Directors of Public Health in London to support more effective engagement with licensing processes.

Members of the dialogue presented findings from discussions at a series of meetings and conference throughout 2012/14, reaching over 800 licensing and health

stakeholders including local and national policymakers, health and licensing practitioners, academic researchers, and legal specialists.

The work of the dialogue group played an important role in disseminating Scottish experiences of health engagement in licensing across England; it helped to clarify a number of the challenges facing both health and licensing teams in regard to establishing effective working relationships under the amended 2003 Licensing Act; and it drew further attention to the need for health data to be both relevant and practical in a licensing context. It also confirmed the importance of establishing capacity-building forums as a critical stage in the long-term development of public health as a meaningful contributor to the licensing process. This work will continue through the activities of the PHE Licensing and Public Health Network, with the goal of establishing public health as a routine consideration within licensing practice across the UK. This approach would, undoubtedly, be strengthened by the addition of a health-oriented licensing objective in primary legislation for England and Wales; however, progress is being made in the absence of that legislative change.

## Evaluation

During the course of this project, there was a comprehensive three year evaluation of the implementation of, and compliance with the objectives of the Licensing (Scotland) Act 2005 undertaken by the Scottish Centre for Social Research (ScotCen) on behalf of NHS Health Scotland (NHS Scotland, 2013). AFS was represented on the advisory group for the ScotCen evaluation and the findings of the work undertaken for this project were communicated to the evaluation team.

Aspects of the legislation which the evaluation identified as being viewed most positively included:

- Role and function of Licensing Standards Officers (LSOs)
- Increased powers for licensing boards (boards)
- Training for LSOs, board members and trade staff
- Relationships between boards, LSOs and trade staff
- Fewer irresponsible promotions in pubs and clubs.
- Possible reduction of direct sales of alcohol to underage young people

The evaluation also identified issues which provoked a more mixed response including:

- Role and function of licensing forums
- Public health objective
- Defining and measuring capacity and overprovision
- Impact on the off trade sector
- National and local data

Despite the overall positive reception for the Act, there were a number of issues identified that could potentially be improved. The evaluation made a number of recommendations about the alcohol licensing regime in Scotland. Of most relevance to this project are recommendations on the improvement of guidance on the public health objective and overprovision; and the development of more consistent and relevant data collection methods to enable publication both locally and nationally of a minimum dataset to inform licensing policy and practice. These recommendations mirror the ongoing challenges to licensing for public health identified by this project.

In addition to participation in the ScotCen evaluation advisory group, AFS collected further evaluation data through questionnaires collected at the regional events; documentary analysis including analysis of licensing board policy statements and telephone interviews with a range of licensing stakeholders in two case study areas, Edinburgh City and Scottish Borders.

## Regional Event Questionnaires

At each of the six regional events, participants recorded their level of agreement with five statements to gauge the impact of the events on their knowledge, understanding and confidence in relation to the information and recommendations in the *Re-thinking Alcohol Licensing* report.

Participants used a scale of 1 to 5 to rank their level of agreement with the following statements (1 = strongly agree; 5 = strongly disagree).

- a) I have an understanding of the shift in purchase patterns and the importance of regulating off-sales as well as on-sales.
- b) I have an understanding of how local evidence, including health statistics, should be used in the creation of licensing policy.
- c) I feel confident about the licensing board being able to include the overall effect of licensed premises in licensing policy.
- d) I feel confident about the licensing board being able to use licensing policy to guide day-to-day decision-making.
- e) I am clear about the actions I/my stakeholder group can now take to better support the public health objective.

The results were analysed by event and stakeholder group. Analysis showed that following the events a high proportion (84%) of all participants agreed or strongly agreed that they had an *understanding of the shift in purchase patterns and the importance of regulating off-sales as well as on-sales*.

There was more variance across stakeholder groups in response to statement b) *I have an understanding of how local evidence, including health statistics, should be used in the creation of licensing policy*. 100% of health participants rated their agreement at 1 or 2 compared with 69% of licensing board participants suggesting that a minority of licensing board participants still had some reservations about accessing or utilising health evidence available in their local area.

Just over half of the licensing board representatives agreed with statement c) *I feel confident about the licensing board being able to include the overall effect of licensed premises in licensing policy*. However, only 7% of health representatives strongly agreed or agreed.

There were slightly more positive responses to statement d) *I feel confident about the licensing board being able to use licensing policy to guide day-to-day decision-making*. Health representatives recorded the lowest level of agreement at just 27%, while 69% of licensing board representatives recorded agreement.

Support for statement e) *I am clear about the actions I/my stakeholder group can now take to better support the public health objective* varied per stakeholder group. Those recording the highest levels of confidence were licensing boards, health representatives and local licensing forum representatives, with police and licensing

standards officers generally recording lower levels of confidence. This could in part be explained by the events being aimed at licensing board personnel and public health representatives. Information provided at the events with regards to roles and actions may not have been as relevant or specific to police and licensing standards officers.

Higher levels of attendance were achieved at each regional event than anticipated and each target stakeholder group was well represented with a relatively even split at each event between licensing personnel and those with a health remit. Levels of understanding with regards to the need to regulate both on- and off-sales and the need to use local evidence in creating licensing policy were generally high across all stakeholder groups. However, confidence levels with regards to considering the overall effect of licensed premises and using licensing policy to guide decision-making was comparatively low. The toolkit which followed the regional events was designed in response to these issues as a 'how to' guide to the policy making process.

## Case Study Area Telephone Interviews

Two case study areas (Edinburgh and the Scottish Borders) were selected for follow-up telephone interviews. This provided one heavily populated urban centre with a thriving night time and tourist economy in Edinburgh, and one more rural area with clusters of the population in small and medium-sized towns in the Scottish Borders. Due to time limitations and the need to ensure access to key stakeholders, areas with good existing relationships with AFS were selected. This meant that access was not unduly problematic or time consuming but may risk slightly skewed opinion in favour of the materials and support provided by AFS. The interviews explored participants' experience of the licensing policy development process in 2012/13, with a particular focus on the interaction between licensing personnel and public health representatives, and the support materials and opportunities provided by AFS.

Eight semi-structured interviews were conducted. In the Scottish Borders, interviews were conducted with the convener of the licensing board, the licensing clerk, the ADP development officer and the Licensing Standards Officer (LSO). In Edinburgh interviews were conducted with a member of the licensing board, the licensing clerk, the convener of the licensing forum and the ADP manager. In both cases the ADP representatives were contributing from a public health perspective but had also coordinated alcohol data profiling projects to gather and present data from health, police and community safety to inform licensing policy development.

Summary findings were as follows:

- In both areas an improvement in the policy development process since 2010 was noted by interviewees with particular reference to wider engagement and consultation with stakeholders, and the availability of more robust evidence to inform the policy. However, the impact on policy and decision-making of the perceived improvement in process varied between the two areas.

- In both areas licensing forums were perceived to be of central importance in the boards' ability to obtain the necessary information and evidence on which to base their policies.
- In both areas the licensing forums had notable significant input from the ADPs, public health and police. In each area the ADP had led on alcohol data profiling work to inform the licensing policy with endorsement from the licensing forum. This appeared to be an effective approach to engaging with licensing board members on health evidence.
- In both areas a lack of community representation and trade representation was reported as problematic and a gap that needed to be addressed.
- In both areas there was a perception that understanding and awareness of the relationship between licensing and public health had improved since 2010, attributed to increased and improved engagement with health partners.
- Overprovision was still regarded as problematic in practice but some progress had been made in both areas.
- The outputs from this project (regional events, licensing toolkit, information dissemination via conferences and events and support to ADP and public health partners) had been received positively. The toolkit in particular was cited as having contributed to an improvement in the policy development process in each area.

### Licensing policy development process

Interviewees were asked to consider the licensing policy development process in 2013 in comparison to the previous policy development process in 2010 and to note any differences. In Edinburgh, those who had been involved in both processes noted an improvement in 2013 with particular reference to wider engagement with stakeholders via consultation. It is worth noting however, that the licensing board member stated that while the consultation process was better and the engagement of a wider range of stakeholders was very positive, they did not believe that the licensing board had acted upon the information received and expressed disappointment and frustration that the health and police evidence provided was not given serious consideration.

*“There was wider discussion on the policy this time in comparison to the previous time...This time around there was wider consultation, good responses but I don't believe the board has acted upon the information...Health and police provide statistics based on hard facts. It is disappointing that this evidence isn't given the serious consideration it warrants. It's quite shocking actually.”* (Licensing board member, Edinburgh)

### Consideration of health and other evidence

Neither the licensing clerk nor the ADP manager in Edinburgh had been involved in the development of the 2010 licensing policy but both noted their involvement in the subsequent development of the overprovision policy for Edinburgh in 2011. The clerk

felt that the work on overprovision in 2011 had been informed by quite a limited consultation in comparison with 2013. The ADP manager on the other hand had found the overprovision policy development in 2011 more positive due to good partnership working and the level of access to the licensing board afforded to the ADP.

*"The work in 2011 differed in respect of working with the licensing clerks on the overprovision statement, briefing the convener, and being invited to the board away-day. There was much more opportunity to engage with the board and clerk. The change in administration in 2012 led to a change in convener and some members of the board. The new board have shown less interest in overprovision."* (ADP Manager, Edinburgh)

This highlights the importance of an accessible and engaged licensing board in having health evidence considered and acted upon. It also highlights the importance of the relationship with board members and the challenge faced by all licensing stakeholders if and when there is a change of local government administration which results in a change in board membership and/or convener. As experienced in Edinburgh, this can result in a complete change in policy direction and in the access and engagement those providing information, data and evidence have with the board.

In the Scottish Borders, partners involved in the gathering and presentation of health evidence sought to address this issue by proactively and directly involving licensing board members in the evidence-gathering work. Interviewees in the Scottish Borders also noted an improvement in the policy development process in 2013 in comparison to 2010. It was particularly noted that this was due to the availability of more robust evidence, coupled with a greater awareness among licensing personnel of the importance of an evidence-based policy.

*"The most important aspect of the policy development this time was recognising and being aware of the need for a sound evidence base for the policy."* (Licensing Standards Officer, Scottish Borders)

The ADP development officer led on the establishment of a short-life working group to provide alcohol-related data and evidence to assist with the licensing policy development process. The impetus for this came from the licensing forum's consideration of *Re-thinking Alcohol Licensing*. The working group included ADP support team, police, the local authority (a data analyst, the licensing clerk and the LSO), health representation including local addiction services, A&E and the ambulance service, and the local fire and rescue service. It was noted with importance that the group sought and secured the membership of two licensing board members, to ensure 'buy-in' to the process. Importantly, the Scottish Borders also experienced a change in administration halfway through the data collection project, but it was felt that the involvement of licensing board members in the working group went some way to minimising the possible negative impacts of the change that Edinburgh had experienced.

*“A change in council administration in the middle of the project meant that the group had to put additional effort into winning the hearts and minds of the new elected members who had not been involved before. One of the councillors on the short-life working group at the time opted to stay on to see the work finished which helped provide a ‘champion’ to encourage elected member buy-in and support.”* (ADP development officer, Scottish Borders)

## Role of the licensing forum

In both case study areas the licensing forum is considered to be of central importance to the support that the licensing boards receive in terms of evidence, information and input. The board members and clerks all made reference to the value of the licensing forums but also specifically mentioned valued input from the ADPs and police services. In both Edinburgh and the Scottish Borders the ADP and the police appear to play a prominent role in the licensing forums. In both areas the ADP led on the evidence-gathering projects but the resulting reports were either submitted by the licensing forum (Scottish Borders) or endorsed by the licensing forum (Edinburgh). Interviewees involved in the evidence-gathering work felt this was an effective approach in engaging the licensing board in the evidence. This belief corroborates the licensing officials' positive regard of the licensing forums' contributions.

## Gaps in engagement

Interviewees were asked whether there were any stakeholder groups that were not well engaged with the licensing process. All noted a need for improved community engagement and improved engagement with the licensed trade. Interviewees from both areas expressed disappointment at the lack of trade engagement in the policy consultations, and in general with the lack of community participation in the licensing process. Board members from each area expressed the view that community or public opinion had the potential to influence licensing policy and decision making.

*“I don't think we hear enough from community groups like Community Councils... We should go out to local community groups and ask them what they think...If we took a different approach I think we'd see a huge response...the health representations tend to be fairly standard with similar information always being given...Accompanying this with community opinion would have an even bigger impact. Community input paints a different picture.”* (Licensing board member, Edinburgh)

*“The local licensing forums should be a way for the general public and those involved in the licensed trade to engage in the work of the board and alcohol in general. Anything that can be done to help raise the profile of forums would be welcome.”* (Licensing board convener, Scottish Borders)

## Promotion of the public health objective



Interviewees were asked whether any progress had been made over the past two years with regards to licensing boards' understanding and promotion of the public health objective. Without exception they reported an improved general awareness of the public health objective and an appreciation of alcohol harm in a wide sense. None, however, felt that improved awareness and understanding was necessarily being translated into licensing decision-making.

*"The board is well aware of the concept of the public health objective...So far as month to month board business is concerned, other than representations about particular applications, there is very little mention of the public health objective. Much of the consideration of their business is more focused on the other licensing objectives. This is possibly because it is difficult to make a direct link in terms of individual applications."* (Licensing clerk, Edinburgh)

### Awareness and understanding of overprovision

The same question was asked with regards to overprovision. In Edinburgh, the ADP manager held the view that overprovision as a concept was understood by partners other than the licensing board and that awareness and understanding had been raised by the work carried out by the ADP to inform the licensing policy. The board member and the licensing clerk noted that overprovision was still a contested and often misunderstood concept among board members.

*"I don't think Edinburgh heeds the warnings from health. Certain members of the board are not interested in those arguments...Business interests have an influence which is sometimes unhelpful. Claims are made about the negative economic impact on the city of overprovision but there is no evidence to support this claim."* (Licensing board member, Edinburgh)

Limited understanding of overprovision and the role of licensing in controlling availability is further demonstrated in views expressed by the convener of Edinburgh licensing forum.

*"There seems to have been a lot of consultation but not a lot of listening. People don't really understand what public health and overprovision mean. There may be a general understanding, but the detail of how they apply in practice is difficult. There is a risk that overprovision policies stifle competition. Competition can make a big difference to the offer to the public. It really is a difficult issue."* (Licensing forum convener, Edinburgh)

In the Scottish Borders, similar views on overprovision were expressed but were not felt to be of significant consequence because overprovision had not been identified as being of major concern by any of the partners given the area's geography and profile of licensed premises. All interviewees in the Scottish Borders identified overprovision of large off-sales premises as a potential problem in the future, but were confident that the way in which this had been reflected in the policy gave them sufficient scope to deal with the issue as and when it arose.

*“The new policy states that the board will look carefully if more than ten percent of the area of an off-licence premises is given to alcohol. The focus will be on off-sales specifically, and the board will ask for information on the types and strength of alcohol the premises plans to sell. The board will look to identify what new applications give that isn't already available and what it will bring to the local areas. This approach will be applied to the whole of the board's area though a specific declaration of overprovision is not given.”* (Licensing clerk, Scottish Borders)

*“The policy now states that the board is aware of the changing pattern of alcohol sale and consumption with seventy percent of all alcohol consumed being sold in off-sales and when considering applications for off-sales they will take account of the overall supply of alcohol in the Borders...The policy also now states that any application for off-sales with no on-sales provision that replicates similar premises in the area is likely to be considered overprovision...This is in line with the public health input we have had.”* (Licensing board convener, Scottish Borders)

## Support from AFS

Finally, interviewees were asked about their views on the usefulness of the materials and opportunities provided to them by AFS during the course of this project in the furthering or strengthening of links between licensing and public health.

Those who had attended the regional events in 2012 noted their usefulness in promoting discussion and generating thinking. Most of those in attendance at the regional events did not report forging any new relationships as a result but rather reinforcing existing relationships between licensing and health representatives. Interviewees from the Scottish Borders reported good collaboration between licensing and health, noting that criticisms of health arguments were less common due to that good working relationship.

*“The health line in particular was an area of challenge so it was helpful to have that covered in detail. The event helped to reinforce good existing links in the Borders. The licensing board area is co-terminus with the Health Board and there is good representation from the ADP. The ‘health lobby’ arguments don't really stand up in the Borders as links are so well reinforced by the council and health's joined-up working.”* (Licensing clerk, Scottish Borders)

The majority of interviewees noted the particular usefulness of the licensing toolkit as a guide and reference to the policy development process. Those representing public health tended to provide more detailed views on how the toolkit had been utilised to guide evidence-gathering and presentation. Those working in licensing tended to view the toolkit as more of a reassurance of the work they were doing. There was more evidence of the toolkit having been used in the Scottish Borders compared with Edinburgh.

*“The fact sheet on a suggested timeframe for licensing policy development helped prompt action to start the process. The toolkit was also useful in terms of advising on available data and identifying points of influence.”* (ADP manager, Edinburgh)

*“The AFS toolkit was fundamental to the development of licensing policy in the Borders. It was used as the basis for the alcohol data profile work. The factsheets have been used to inform presentations to stakeholders.”* (ADP development officer, Scottish Borders)

*“The toolkit was useful in setting out things the board should have in mind when developing its policy and helps to set the context.”* (Licensing clerk, Edinburgh)

*“It is like a nice comfort blanket, very helpful. It provided reassurance of what we were doing. The policy development relied a lot on the alcohol data profile being prepared by the ADP and the toolkit supported the principle of working from such a profile.”* (Licensing clerk, Scottish Borders)

## Statements of licensing policy

The resulting statements of licensing policy in the Scottish Borders and Edinburgh reflect the experiences reported in interviews, highlighting some ongoing difficulties in effectively engaging with and influencing licensing policy and decision making in the public interest.

In Edinburgh, the 2013 licensing policy provides little information on relevant health evidence relating to promotion of the licensing objectives and information on measures it would expect to see with regards to licence applicants promoting and improving public health is predominantly focused on the provision of information on units of alcohol, responsible drinking and the management of intoxicated patrons. The previous policy's position on overprovision is maintained, identifying a relatively small area of the city as being overprovided with both on-licence and off-licence premises. This is despite significant support from health partners, police, community safety and the local licensing forum for a substantial increase in Edinburgh's overprovision area as recommended in Edinburgh ADP's alcohol profiling report. The report recommended the identification of seven new areas of the city as overprovided based on the available evidence of health and social harm. The recommendation was endorsed by the forum and by submissions to the policy consultation from a wide range of stakeholders including local government parties, the police, community safety and local community groups. The licensing board, however, opted to identify the seven areas as 'areas of serious, special concern'. This is a term that does not appear in licensing legislation and is therefore not defined, leaving those partners who called for an increase in the designated overprovision area frustrated and uncertain of the impact on licensing decisions in those areas. This is discussed further in section 4.4 on implications for practice. Furthermore, there is no acknowledgement in the overprovision section of the policy statement of the potential health harms associated with overprovision, whereas a range of public order issues are outlined and acknowledged as being of concern.

In the Scottish Borders, the 2013 licensing policy includes information on the impact of alcohol harm related to each of the licensing objectives. Under the public health objective it notes in particular, the impact of excessive alcohol consumption on

frontline health services. The policy provides information on measures the licensing board would expect licence applicants to include to promote and improve public health, broadly similar to those suggested by Edinburgh licensing board. Scottish Borders licensing board does not declare overprovision in any area but does acknowledge the potential for overprovision to become a problem in the future if not carefully monitored and controlled. The policy goes into some detail on when and how overprovision will be considered with regards to applications for large off-sales premises and indicates the circumstances in which the board may decide not to grant a licence based on overprovision. The policy notes the valuable contribution of evidence from the licensing forum, ADP and police stating that this evidence will be used in consideration of all potential overprovision situations. It further acknowledges concern about changed drinking patterns with more consumption taking place in private settings, driven by the availability of cheap alcohol from large off-sales. In the absence of declaring an area as overprovided for, the policy appears to provide the board with the means to use an overprovision argument in licensing decisions should they so wish. All interviewees from the Scottish Borders were satisfied with this position and felt it reflected local circumstances appropriately.

## Analysis of Licensing Board Policy Statements

Licensing boards in Scotland are required to publish a statement of licensing policy every three years, the most recent due for publication in November 2013. The policy sets out the general approach a licensing board will take to promoting the licensing objectives and regulating the sale of alcohol and licensed premises in its area.

There are forty licensing boards in Scotland producing a total of thirty-six licensing policies covering Scotland<sup>2</sup>. In 2010 AFS conducted basic analysis of the thirty licensing policy statements available (30 from a possible 36). The analysis showed very limited use of evidence in the formation of policies, particularly health evidence. Of the thirty statements analysed, only three specifically mentioned the use of health data. In general, sources of data and evidence were not well cited. It is therefore difficult to properly assess the use of health evidence overall. With regards to the number of boards carrying out assessments of overprovision, only seven of the thirty policies had declared overprovision in any part of the board area. Of those seven, only one had applied an overprovision policy to a large geographical area based on the evidence of alcohol related harm available to them. The other six had declared overprovision in small areas, specific streets or 'hotspots' which tends to point to a predominant focus on public order issues.

On the basis of this information and the contact that we have had with public health and ADP colleagues during this project, we anticipated that the analysis of the 2013 licensing policy statements would demonstrate some impact of the improved engagement with public health evidence in comparison with 2010 statements. For the purposes of evaluation for this project, comparisons will be drawn between elements of the policy statements in 2010 and in 2013.

As of May 2014 twenty-five of thirty-six licensing policies for 2013 – 16 had been published. Those still to publish were in the process of consultation or evidence-gathering for either the whole policy or the overprovision part of the policy. There does not appear to be any penalty for licensing boards publishing policies later than stipulated in legislation.

AFS has conducted a content analysis of the available policies with particular focus on:

- Presentation, accessibility, succinctness, language use and length of statement
- Inclusion of contextual information and use of evidence
- Consultation
- Licensed hours
- Overprovision
- Children's access to licensed premises

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<sup>2</sup> Most licensing boards in Scotland cover an area co-terminus with the local authority. However some local authorities are sub-divided into multiple licensing board areas resulting in forty licensing boards covering thirty-two local authorities. The four divisional licensing boards in Dumfries & Galloway and two of the three divisional licensing boards in Aberdeenshire publish joint statements of licensing policy giving a total of thirty-six policies covering Scotland.

- Occasional licenses
- Imposition of conditions to promote the licensing objectives

For the purposes of evaluation and impact assessment related to this project, this report provides information on the inclusion of contextual information and the use of health evidence in the policies, licensed hours and overprovision as they provide the most readily comparable areas to evaluate any progress since 2010 relating to the influence of public health.

### Inclusion of contextual information and use of health evidence

The inclusion of contextual information in the policy documents assist the reader to understand the reasoning for the licensing policy and make sense of particular policy positions adopted. If the primary purpose of the regulation of the sale of alcohol and licensed premises is to prevent and reduce alcohol problems, then it is appropriate to consider policy formulation in the context of the nature and scale of problems related to alcohol use in localities.

Among the available 2013 policy statements, there is a mixed picture on the inclusion of contextual information.

- Although most policy statements include some relevant contextual information, it is often minimal.
- 15 policy statements provide basic licensing statistics. 21 contain some population information. However, the relevance of this information to the formulation of licensing policy is generally not made clear.
- Three policy statements do not include any contextual information or supporting evidence.
- Five policy statements stand out for presenting licensing policy in context, summarising the evidence, and providing meaningful explanation for a particular policy approach. These are: Glasgow City; Scottish Borders; Aberdeen City, Dumfries and Galloway, and Highland.

While the majority of licensing policies in 2013 contain some contextual information, it is disappointing to note that three policies contain no contextual information at all. Of those that do contain contextual information, only five stand out as having done so in an effective and meaningful way. It is not possible to compare this information with 2010 as contextual information did not form part of the previous analysis. It is possible however to suggest that there is room for improvement here. Licensing policies should be accessible and open to public scrutiny. A lack of contextual information makes this difficult. In order to promote the public interest purpose of licensing basic contextual information should be included in policy statements as standard.

The analysis of the use of evidence in the development of the 2013 policy positions is more comprehensive than the 2010 analysis. The 2013 analysis took account of the important distinction between the general use of evidence to formulate policy and the explicit demonstration of health evidence within the policy statement. In 2013:

- In the majority of statements, the general evidence base for the policy approach is not demonstrated. Often little and sometimes no explanation is provided for why particular policy positions are adopted.
- More policy statements highlight the contribution of the licensed trade to the economy and tourism of a local area, than mention any adverse health and social consequences linked to alcohol, which the licensing system is there to address.
- Most of the policy statements include a statement on 'having regard to' or 'taking the views of' health bodies, but only 9 out of 25 statements demonstrate the use of health evidence within the content of the policy.
- Less than half of the statements of licensing policy published in 2013 demonstrate or reference the health evidence that has been used to reach the policy position. It is difficult to assess the extent to which this indicates health evidence has not been considered.

In order for licensing policy to be accessible, transparent and subject to public scrutiny, licensing boards should include information on the evidence that they have considered in their published policy statement.

In comparison with the 2010 analysis, there has been some progress. Only nine percent of policies analysed in 2010 made reference to any form of health evidence. This compares to thirty-six percent in 2013, confirming that reference to the use of health evidence has improved.

*Table 4: Number of Statements of Licensing Policy that cite health evidence*

|  | <b>2010</b> | <b>2013</b> |
|--|-------------|-------------|
| <b>No. of policies citing health evidence</b>        | 3           | 9           |
| <b>% of policies analysed citing health evidence</b> | 9%          | 36%         |

## Licensed hours

Statutory guidance stipulates that policy statements should provide information on a licensing board's policy on licensed hours. In the 2013 statements, as in previous policy statements, most licensing boards indicate what they regard as being standard operating hours.

Under current legislation, only off-sales hours are specified in law. Off-sales are allowed between 10am to 10pm Monday to Sunday, although licensing boards can decide to grant more limited off-sales hours if they consider it appropriate. It is left to each licensing board to determine the licensed hours for on-licensed premises, although there is a presumption in law against granting 24-hour licences.

In the 2013 statements of licensing policy, policies on standard operating hours and extended hours vary with regard to the times and conditions set. Trends in the extension or contraction of licensed hours have been considered by examining licensing policies from 2007, 2010 and 2013:



- Over the past six years, at least 17 licensing boards have changed their policy to extend normal licensed hours.
- 1 licensing board has reduced licensed hours.
- 1 decided against increasing licensed hours following a consultation.

Due to the lack of consistent information on the evidence used to formulate policy positions in licensing policy in 2013, it is impossible to assess how licensed hours have been impacted by evidence or arguments from health representatives. Since almost half of the licensing boards in Scotland have extended operating hours over the past six years, it appears that evidence on links between temporal availability, consumption and harm has not proved decisive. One common consideration is the perceived lack of public support for policies that restrict access to alcohol; however, an extension to licensed hours in the city of Glasgow was proposed but subsequently withdrawn in response to public opposition.

## Overprovision

The Senior Counsel opinion commissioned as part of *Re-thinking Alcohol Licensing* identified the overprovision policy as the most obvious control for protecting and improving public health. The guidance accompanying the legislation explains that halting the growth of licensed premises in localities is not intended to restrict trade but may be required to preserve public order, protect the amenity of local communities, and mitigate the adverse health effects of increased consumption resulting from growing outlet density.

As discussed at the start of this section, the use of overprovision in the 2010 policies was very limited with only seven out of thirty identifying any areas as overprovided and a tendency to focus on city or town-centre streets or other small 'problem areas', usually based on public order issues. Only one board had identified overprovision across a wider area taking account of health evidence along with public order issues.

In 2013 we have seen some progress on overprovision with an increase in the number of boards declaring overprovision and an increase in boards declaring overprovision across wider geographical areas.

Six of the twenty-five published licensing policy statements do not yet include a policy on overprovision. Those six areas have either elected to undertake the overprovision assessment separately to the licensing policy development with a view to adding a supplementary policy once the assessment is complete, or they are currently consulting on a draft overprovision policy which will inform the final policy.

Of the overprovision statements included in statements of licensing policy published in 2013/4:

- 10 have declared overprovision in any part of their area.
- 5 have declared overprovision across a wide area, 5 have more limited areas of overprovision.
- 4 new boards have declared overprovision in 2013 that did not in 2010.



- 3 boards which declared overprovision in 2010 have extended the area of overprovision in 2013.
- 8 licensing boards do not provide any explanation of how they reached their decision that there is no overprovision in their area or the evidence they took into account in formulating their policy position.
- No policy statement includes relevant licensing statistics in the section of their policy dealing with overprovision.

This is an improved position to that of 2010. The case study interviews suggest that increased awareness and understanding of the links between availability, consumption and harm is attributable to input from health and ADP partners, particularly where they collaborate on the gathering and analysis of evidence with others such as the police and community safety. While it is an improved position in comparison to 2010, there is room for further improvement.

*Table 5: Number of licensing policies declaring overprovision*

|   |                     | 2010 | 2013 |
|---|---------------------|------|------|
| <b>Policies declaring overprovision in any area</b>                     | No.                 | 7    | 10   |
|   | % of those analysed | 23%  | 52%  |
| <hr/>   |                     |      |      |
| <b>Policies declaring overprovision across a wide geographical area</b> | No.                 | 1    | 5    |
|   | % of those analysed | 3%   | 26%  |

There has been an increase in the number of boards identifying areas of overprovision between 2010 and 2013 and an increase in those identifying overprovision across wider geographical areas. Telephone interviews suggest that improved awareness, understanding and decision-making based on the overall availability of alcohol in a board's area is a contributory factor to this.

## Impact and Implications for Policy and Practice

A key outcome for this project was to increase understanding of the links between alcohol availability and harm amongst licensing stakeholders in Scotland and the UK. The activities undertaken as part of this project aimed to increase public health and ADP engagement in the licensing process with a view to influencing licensing policy and decision-making to take more cognisance of alcohol health harm and the impact that availability has on consumption patterns and levels of harm. Evaluation activities during this project have demonstrated what would appear to be an increase in engagement on the part of health and ADP partners. Information gathered in the case study telephone interviews demonstrates coordinated efforts on the part of health and ADP partners to provide information and evidence to inform licensing policies. Licensing personnel interviewed as part of the case studies spoke of valuing the input from health partners. Changes in attendance at the annual National Licensing Conference run by AFS also reflect an improvement in health partners' engagement in licensing. Last year's conference held in September 2013 saw the highest level of attendance by health practitioners and ADPs ever achieved by the conference. 23% of delegates in 2013 represented health or ADP organisations compared with just 7% the previous year. The increased engagement of ADP and public health partners in the policy development process does not always translate into the resulting policy or decisions of licensing boards.

The evaluation of the implementation of the Licensing (Scotland) Act 2005 conducted by Scotcen for NHS Health Scotland's MESAS project identified areas requiring ongoing support including an improvement of guidance on the public health objective and overprovision, and the development of more consistent and relevant data collection to inform licensing practice. These recommendations reflect the evaluation data gathered for this project.

Questionnaires distributed at the regional events held in 2012 indicated a lack of confidence on the part of licensing boards in their ability to use health statistics in the formulation of licensing policy and a general lack of confidence among all stakeholders in the ability of licensing boards to consider the overall availability of alcohol when developing the licensing policy statements.

The work of this project sought to address this lack of confidence by increasing awareness and understanding of the links between licensing and public health. The project outputs were designed to build confidence and capacity within licensing and public health sectors to make use of licensing as a tool to control availability of alcohol to protect and improve public health.

### Areas where impact has been demonstrated

Evidence gathered during the project suggests that public health partners have increased engagement and participation in the licensing process and that this is beginning to have a positive impact on awareness and knowledge of health evidence in some areas. A significant increase in attendance from public health and ADP partners at our annual National Licensing Conference has been observed between 2012 and 2013 conferences. This resulted in the 2013 conference having a more balanced representation of views and opinions on licensing and alcohol availability.

The case study area telephone interviews demonstrated significant input to the licensing policy development processes in Edinburgh and the Scottish Borders from health partners, particularly the ADPs. In both areas the ADP coordinated bringing together relevant partners to gather, analyse and interpret alcohol-related data. In both areas that data and evidence was presented to the licensing boards along with recommendations on licensing policy positions that would assist in addressing rates of alcohol harm. Those recommendations have been incorporated into the 2013 policies in each area to some extent though in one area health partners are frustrated by resulting policy position, particularly with regards to the overprovision statement. In both areas the ADPs continue to play a role in coordinating data-collection and making representations to the licensing boards, and they are beginning to develop community engagement mechanisms with a view to enhancing public participation in the licensing process. While this project has not gathered formal evidence of this nature in other parts of the country, our engagement with groups such as the Alcohol Special Interest Group of Consultants in Public Health Evidence has provided anecdotal information that similar work is being undertaken in other parts of Scotland led either by the ADP or the local health board's public health department. This would indicate that efforts to increase the engagement of public health partners in licensing has been relatively successful. Evaluation information has shown however that increased engagement does not always lead to improved policy positions.

The analysis of statements of licensing policy in 2013 in comparison with those published in 2010 does show some progress: it shows an increase in the use of health evidence in policy development as well as an increase in the number of boards identifying overprovision, one of the key tools within licensing legislation to promote the public health objective. This suggests increased awareness and understanding of the relationships between availability, consumption and harm, and an increased willingness to use overprovision policies as a mechanism to regulate outlet density, but only in a minority of licensing boards.

### Areas requiring further work

While impact has been demonstrated with regards to public health partners' engagement and influence on licensing policies and decisions, evaluation information has shown that the degree of impact that health data and evidence has is still subject to varied interpretations of the evidence by licensing board members and officials. While there appears to have been progress on the process of evidence gathering, consultation and stakeholder engagement, the policy outcome does not always reflect the health evidence presented.

Reports from telephone interviews suggest that, in some cases, the extent to which health evidence is considered and acted upon can be based on the political leanings or interests of individual board members. Those in favour of promoting business and economic objectives can be less receptive to health evidence. The analysis of contextual information in statements of licensing policy also shows that economic considerations are often acknowledged before other licensing objectives, including health.

Having evidence heard and acknowledged requires considerable work on the part of health representatives to build relationships with licensing officials. Where changes in

local government administration occur, resulting in changes to board membership, this 'ground-work' has to be repeated. If less access to licensing board members and licensing officials is granted to health partners following a change, it can have a detrimental impact with regard to the acknowledgement of health evidence.

Some progress has been noted in the use of health evidence in licensing policies, and in the identification of and action on overprovision, in 2013 in comparison with 2010 but there are still areas of policy that require further work. The analysis of policy statements from 2007 to 2013 showed a trend in the extension of licensed hours in most board areas. This would suggest that while there has been some increase in awareness and understanding of the links between availability, consumption and harm in some areas, the increased temporal availability is not considered a key risk factor by most licensing boards. A small number of licensing boards in 2013 appear to question the link between the number of licensed premises in a locality and alcohol-related problems so increases in awareness and understanding are not demonstrated across all areas.

### Implications for policy

During this project, the Scottish Government undertook a consultation on licensing. In December 2012, the consultation paper *Further Options for Alcohol Licensing* was published and sought views on a number of proposals for improving the function of licensing in Scotland. Many of the proposals contained within the consultation were based on recommendations made in the *Re-thinking Alcohol Licensing* report. Of the thirteen recommendations to the Scottish Government made in *Re-thinking Alcohol Licensing*, eight were contained within the consultation. Alcohol Focus Scotland submitted a response to the consultation and provided support to licensing stakeholders across Scotland including ADPs and Local Licensing Forums to submit their own responses. The consultation document and Alcohol Focus Scotland's response can be viewed [here](#).

On 14 May 2014, the Scottish Government published the Air Weapons and Licensing (Scotland) Bill containing a section on alcohol licensing based on the *Further Options for Alcohol Licensing* consultation. The policy objectives of the Bill include strengthening and improving aspects of alcohol licensing to preserve public order and safety, reduce crime and advance public health. The Bill makes a number of technical recommendations to clarify and improve the operation of current alcohol licensing legislation including some of the recommendations from *Re-thinking Alcohol Licensing*:

- An amendment to the objective of 'protecting children from harm' to include young people;
- An amendment of the duration of a statement of licensing policy to better align with the term of a licensing board;
- Clarification that for an overprovision assessment, the whole board area can be considered an area of overprovision;
- Allowing boards to take account of licensed hours among other things in the assessment of overprovision.

The inclusion of young people in the objective 'to protect children from harm' closes a legal loophole in which young people aged sixteen or seventeen years old were not included under the objective.

The Bill proposes that a statement of licensing policy should be produced within eighteen months of the board being appointed and last for a duration of up to five years. This improved alignment of policy with a board's term both reduces the burden on boards and provides more time to ensure that statements are robust, evidence-based and capable of withstanding legal challenge.

The clarification of the area that can be assessed as overprovided addresses a contested section within the current legislation which can be misinterpreted to imply that only sections of a board's area can be considered overprovided for. Health indicators are often only available for larger geographical areas presenting an obstacle when considering the evidence of health harm in smaller localities. The inclusion of licensed hours in the assessment of overprovision will enable consideration of the temporal availability of alcohol along with the physical availability of number of outlets and capacity.

The Bill will be scrutinised during 2014 by the Local Government and Regeneration Committee of the Scottish Parliament with calls for the submission of written evidence expected by the end of June 2014. AFS will provide evidence based on the information gathered during this project and will support public health partners in Scotland to participate in the Bill process.

Local consultations on licensing policy have taken place across Scotland and a number of licensing cases have been heard in court, creating case law which is providing a legal reference point for policy and practice. AFS will continue to monitor the implementation of licensing policy.

During the course of this project, the Westminster Government consulted on its 2012 Alcohol Strategy which included proposals to introduce a ban on multi-buy promotions in off-sales, along with other measures to strengthen the licensing objectives and the introduction of health as a licensing objective for cumulative impacts. In July the Westminster Government responded to the consultation results, stating that it would not proceed with the plan for the ban on multi-buy promotions until there was more conclusive evidence of the impact of such a measure (HM Government, 2013). Following its review of the mandatory licensing conditions and consideration of responses to the consultation, the Westminster Government set out the following commitments aimed at making the conditions more effective and more consistently implemented:

- Enable tougher action on irresponsible promotions in pubs and clubs: assisting enforcement and other agencies and the on-trade to tackle crime and disorder and promote the other licensing objectives by simplifying and tightening the law on what constitutes an irresponsible promotion.
- Strengthen measures to help people drink more responsibly: requiring on-trade premises to list the price of small measures, which they must already offer, on menus or price lists alongside the price of other serving sizes. If a customer does not specify a measure, there will also be a requirement to make them explicitly aware of those that are available. These changes will raise customer awareness

of the availability of small servings such as a 125ml glass of wine, half a pint of beer or a single measure of spirits. Clarify that the water that all on-trade premises such as pubs and clubs must offer their customers is drinkable, encouraging them to balance their alcoholic and non-alcoholic consumption.

- Improve age verification requirements: making it clear that responsibility lies with the designated premises supervisor, already responsible for the day-to-day management of the premises, for implementing the age verification policy; and broadening the definition of identification documents which can be used to prove age to include those bearing ultra-violet fluorescent ink. Some foreign passports and identity cards do not bear the holographic mark currently required to be valid as identification for the purchase of alcohol. This will mean that more visitors to England and Wales can be confident of proving their age.

With regards to health as a licensing objective, the government concluded that while there was international evidence showing that controls on outlet density reduced a range of alcohol-related harm including health harm, there was not sufficient local data gathering or processes in place to support the implementation of a licensing objective on health. The government therefore has opted to support the development of local work via 'Local Alcohol Action Areas' to improve local evidence which may support the need to create health as a licensing objective in the future.

It looks likely that the divergence in licensing policy between Scotland and the rest of the UK with regards to using licensing as a public health tool will continue for the foreseeable future. The decision by the Westminster Government not to implement a licensing objective for health may present a further barrier to progress in realising the potential of licensing to improve and protect public health in England and Wales.

### Implications for practice

The project evaluation has demonstrated good progress in strengthening the working relationships between public health and licensing sectors and indicates some signs of increased capacity of licensing boards to give meaningful effect to the licensing objective 'to protect and improve public health' mainly evidenced by increased use of public health evidence in policy development and in developed positions on overprovision in some licensing board areas. However, a number of areas have been identified as requiring ongoing support or action.

Statements of licensing policy for 2013 – 16 have only recently been published. Analysis of the policies indicates some improvement in the use of public health evidence in formulating policy positions in some areas but the translation of new policy positions into licensing decision-making and any impact on the rates of alcohol harm in Scotland is yet to be assessed. Some policies have begun to be tested with licence applications being considered in areas of identified overprovision or areas recognised as experiencing high levels of alcohol harm. In some of these cases licensing decisions raise questions about the extent to which an increase in awareness and understanding of public health evidence results in action to more effectively control alcohol availability. The most recent example of this is in Edinburgh where at its meeting on 28 April 2014, the licensing board granted two new supermarket licences in an area of the

city that the 2013 licensing policy identifies as being of 'serious, special concern' due to levels of alcohol harm. The decision to grant the licences was taken despite representations from public health, Police Scotland and local community groups that the applications should be refused on the grounds of overprovision to prevent further deterioration in the area's poor health and crime rates. Edinburgh is an area in which public health representatives, the ADP and police collaborate effectively with the local licensing forum to gather evidence, produce reports and make recommendations to the licensing board. The licensing board has acknowledged this work in the policy statement but recent licensing decisions would suggest that there is still work to be done to see health evidence applied in practice.

There is a need for close monitoring and scrutiny of licensing decisions in the context of the new policy statements in order to assess the impact of improved policy positions. There is also a need for ongoing support for public health and other partners to continue to promote the use of health evidence in licensing decision-making.

The project has identified a need for better community engagement in the licensing process. The telephone interviews highlighted a perceived gap in community or public engagement in the licensing system. Interviewees reported on the potential benefits of having public opinion more readily available in licensing policy development and decision-making. It would appear that levels of community and public engagement in licensing are currently not sufficient and work needs to be done to improve this, in particular to explore ways to make the licensing system more accessible to members of the public.

Greater accessibility should improve the transparency and accountability of licensing boards to ensure that licensing decisions are taken in the public interest. A number of issues identified by this project point to a current lack of accountability. For example, legislation requires licensing boards in Scotland publish a statement of licensing policy every three years with the most recent policies due for publication in November 2013. In November 2013 only a handful of policies had been published and by May 2014 still only twenty-five of thirty-six policies are publicly available. Of those policy statements published, there is limited provision of contextual information and a minority provide reference to health evidence that has been used to formulate the policy positions. This paucity of information makes it very difficult for stakeholders, particularly community members who may not be familiar with evidence relating to licensing, to adequately scrutinise licensing policies and decisions and hold licensing boards to account. Increased and improved public engagement in licensing may exert some pressure on licensing boards to provide better information.

Telephone interviews suggest that community opinion may influence licensing board decisions in a different and sometimes more effective way than evidence provided by public health or police partners. With this in mind, public health partners may wish to consider the inclusion of community consultation as part of their evidence-gathering activities.

Local licensing forums are one mechanism through which the public can engage with the licensing board, however the evaluation of the implementation of the Licensing (Scotland) Act 2005 found mixed views on the role and function of licensing forums. In the two project case study areas, Edinburgh and Scottish Borders, the involvement of the local licensing forums in supporting or endorsing the evidence-gathering work

undertaken was reported by interviewees as being important in ensuring health evidence was given serious consideration by the licensing board. This approach appeared to be effective in raising the profile of health evidence. However, it was also noted by interviewees that the level of community involvement in the licensing forums was disappointing. This would suggest the need for analysis of the current membership of local licensing forums and consideration of whether they are adequately representative of communities. This may enable the consideration of alternative means of gathering public opinion on licensing issues.



## Conclusion

While impact has been demonstrated with regards to increased engagement of public health in the licensing process, the evaluation has shown that overall, the extent to which health data is used in practice continues to be subject to varying interpretations of the evidence by licensing board members and officials. The licensing policy outcome therefore does not always reflect the health evidence presented.

But whilst the licensing policy outcome does not always reflect the health evidence presented, progress has been made with regards to strengthening the working relationships between public health and licensing stakeholders in Scotland. Signs of increased capacity in licensing boards to give more meaningful effect to the licensing objective 'to protect and improve public health' are evidenced by the increased use of health evidence in licensing policy development and in some published positions on the overprovision of licensed premises. However, when considering the published statements of licensing policy in 2013 as a whole, progress has been relatively limited. Further work is needed to scrutinise licensing decisions in the context of the 2013 statements of policy in order to assess the impact of policy positions. Public health partners should continue to promote the use of health evidence to support licensing decision-making.

The project has involved significant regional work to further understanding and increase dialogue between licensing and public health personnel across the UK. The establishment of the UK dialogue group has enabled the sharing of information, learning and experience providing partners with support and a reference point for their efforts.

In England, the Westminster Government, while acknowledging the international evidence showing that controls on outlet density reduced a range of alcohol-related problems including health harm, concluded that there was not sufficient local data gathering or processes in place to support the implementation of a licensing objective on health. Instead, the government has opted to support the development of local work to improve local evidence which may support the creation of health as a licensing objective in the future.

In Scotland, where protecting and improving public health is a licensing objective enshrined in legislation, there are still obstacles and barriers to this objective being promoted effectively. The work of the project in Scotland has contributed to overcoming some of these barriers by facilitating better relationships and increasing understanding between public health and licensing stakeholders. However, it is clear that more work is needed to make a real and significant impact on alcohol availability and levels of harm.

Given the continued divergence of licensing policy between Scotland and England, it will be important to continue dialogue in order to build capacity to promote and support using licensing to protect public health.

## References

Babor, T. et al. (2010) *Alcohol: no ordinary commodity*. 2<sup>nd</sup> ed. Oxford: Oxford University Press.

Beeston, C., Reid, G., Robinson, M., Craig, N., McCartney, G., Graham, L., and Grant, I. (2013) *Monitoring and Evaluating Scotland's Alcohol Strategy, 3<sup>rd</sup> Annual Report*. Edinburgh: NHS Scotland.

Campbell, C. et al. (2009) 'The effectiveness of limiting alcohol outlet density as a means of reducing excessive alcohol consumption and alcohol-related harms. *American Journal of Preventive Medicine* 37, 556-69.

HM Government (2012) *The Government's Alcohol Strategy Cm8666*. London: HMSO

Nicholls, J. (2012) 'Alcohol licensing in Scotland: a historical overview', *Addiction* 107.8, 1397-403

Popova, S., Giesbrecht, N., Bekmuradov, D. and Patra, J. (2009) Hours and days of sale and density of alcohol outlets: impacts on alcohol consumption and damage: a systematic review. *Alcohol and Alcoholism* 44, 500-16.

Robinson, M. and Beeston, C. (2013) *Monitoring and Evaluating Scotland's Alcohol Strategy: Annual update of alcohol sales and price band analyses*. Edinburgh: NHS Scotland.

Webb, S. and Webb, B. (1963 orig. 1903) *The history of liquor licensing in England, principally from 1700 to 1830*. London: Frank Cass.