

**Exploring stakeholder engagement in public health
commissioning: A case study of local alcohol services**

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Abstract

This research investigates stakeholders' knowledge of, and experience in, public health commissioning of alcohol services in North East England.

Public health commissioning has undergone significant transformation during the course of this research. However, health policies and legislation have consistently supported the concept of stakeholder involvement in all stages of the commissioning process. Alcohol is an issue that spans health and wider public health services. On a global level alcohol is the fifth leading cause of morbidity and premature death and is causally linked to over 60 diseases. The growing recognition of both the harmful effects of excessive alcohol consumption, and the rising associated costs have made it a major public health priority in recent years, both internationally and within the UK. The North East has one of the highest prevalence rates for excessive drinking and alcohol related health inequalities.

A qualitative case study approach was adopted, focussing on the commissioning of alcohol services in a specific local area. Semi structured interviews and focus groups were used to obtain the perspectives of commissioners, alcohol service providers, general practitioners and alcohol service users.

Collectively, all study participants were stakeholders in the commissioning process. However, understanding about what constituted stakeholder involvement was not consistent among participants and often definitions were limited to public and patient consultation. Stakeholder participation was often viewed as an end point rather than a process, the implication being that 'any involvement was good involvement'. Furthermore, participatory approaches did little to ensure that stakeholder involvement actually influenced planning and decision making.

Arnstein's Ladder of participation was used to examine the extent of stakeholder involvement and a revised ladder is proposed. For many stakeholders, contribution to commissioning decisions seemed to occur at a tokenistic level, resulting in minimal motivation for at least some stakeholders to become involved in the commissioning process.

Declaration

The work presented in this thesis has been composed by the candidate Hayley Alderson.

The material has not been previously submitted for a degree of any qualification at this or any university.

The thesis is the candidates own work and all of the work has been completed by the candidate.

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Table of contents

Abstract.....	i
Declaration.....	ii
Acknowledgements.....	iii
List of Tables	vii
List of Figures	viii
List of Acronyms.....	ix
Chapter 1 Introduction.....	1
1.1 Chapter overview:	1
1.2 Alcohol	1
1.2.1 Alcohol use in the North East.....	4
1.3 Commissioning in the English NHS.....	6
1.3.1 The commissioning process.....	7
1.4 Public health.....	9
1.5 Stakeholder involvement in commissioning	10
1.5.1 Stakeholder involvement in alcohol treatment.....	12
1.6 Justification for the research/purpose of the study:.....	13
1.7 Research questions:	13
1.8 Research Design:.....	14
1.9 Overview of thesis chapters:	14
Chapter 2 : Alcohol Commissioning- Background and Context.....	16
2.1 A brief overview of Commissioning Policy.....	16
2.2 Commissioning of Alcohol Services	25
Chapter 3 : Literature Review.....	35
3.1 Chapter overview	35
3.2 Stakeholder involvement in health care	35
3.2.1 Complexities of defining meaning of stakeholder involvement.....	35
3.2.2 The national policy context and benefits of stakeholder involvement.....	36
3.2.3 Stakeholder involvement in commissioning/decision making	38
3.2.4 Models of stakeholder involvement.....	41
3.2.5 Barriers to stakeholder involvement.....	46
3.3 Barriers for professionals- Engagement failure	52

3.4	Chapter Summary	53
Chapter 4 : Methods and Methodology		55
4.1	Chapter overview	55
4.2	Qualitative approach	55
4.3	Ontology: Interpretivism	56
4.4	Epistemology: Social Constructionism	58
4.5	Sampling	58
4.6	Methodology.....	59
4.6.1	<i>A case study approach</i>	59
4.6.2	<i>Interviews</i>	61
4.6.3	<i>Focus Groups</i>	62
4.7	Methods of data collection.....	64
4.7.1	<i>Interviews</i>	64
4.7.2	<i>Focus Groups</i>	73
4.8	Methods of data analysis.....	74
4.9	Transcribing data	77
4.9.1	<i>Data coding</i>	77
4.10	Chapter summary	78
Chapter 5 : ‘Understanding’ stakeholder involvement: stakeholders’ knowledge of and experience in Commissioning		79
5.1	Introduction	79
5.2	Who are stakeholders in alcohol commissioning?.....	80
5.3	What is the stakeholders’ role in alcohol commissioning?	81
5.4	Stakeholder Knowledge <i>of</i> commissioning.....	82
5.4.1	<i>The commissioners’ perspective</i>	83
5.4.2	<i>The General Practitioners’ perspective</i>	89
5.5	Stakeholder Experiences <i>in</i> Commissioning	93
5.5.1	<i>Stakeholder involvement: Rhetoric or reality- A commissioner’s perspective</i>	93
5.5.2	<i>The Clinician’s Voice: Is it being heard?</i>	99
5.5.3	<i>Non participation: choice or oppression- The Service User’s Perspective</i>	102
5.6	Do stakeholders <i>want</i> to be involved in commissioning?	107
5.7	Chapter Summary	112
Chapter 6 : ‘Doing’ stakeholder involvement: approaches, barriers, and challenges.....		114
6.1	Introduction	114
6.2	Mechanisms used to facilitate stakeholder involvement in Alcohol Commissioning	114

6.2.1	<i>Formal processes</i>	114
6.2.2	<i>Informal processes</i>	119
6.3	Ladder of engagement.....	124
6.4	Barriers to stakeholder involvement in commissioning.....	125
6.4.1	<i>Monitoring</i>	126
6.4.2	<i>Unrealistic timeframes or a lack of proactive planning?</i>	131
6.5	Challenges of involving stakeholders in commissioning decisions.....	133
6.5.1	<i>Feeling undervalued:</i>	133
6.5.2	<i>A power imbalance between Commissioners and Providers</i>	135
6.5.3	<i>Conflict of interest</i>	137
6.5.4	<i>Competition between providers: A sense of rivalry and lack of collaborative working</i>	139
6.6	Chapter Summary	143
Chapter 7 : Discussion		145
7.1	Chapter Overview	145
7.2	Key emergent themes from the research:	145
7.2.1	<i>Rhetoric- reality gap regarding stakeholder involvement</i>	146
7.2.2	<i>Obstacles to achieving consistent stakeholder involvement in commissioning</i>	148
7.2.3	<i>Coping with rapid and relentless change</i>	150
7.2.4	<i>How individual level attitudes and awareness shape the commissioning processes</i>	153
7.3	Interpretation of findings.....	155
7.4	Key strengths and limitations of research	160
7.4.1	<i>Reflexivity and practitioner research</i>	160
7.4.2	<i>Validity</i>	163
7.5	Recommendations for policy	165
7.6	Areas for future research	166
7.7	Conclusion	167
Appendices.....		169
References.....		187

List of Tables

Table 1: Alcohol consumption levels	3
Table 2: Categories of alcohol misuse	3
Table 3: Tiers of alcohol service.....	29
Table 4: NICE Alcohol guidelines	31
Table 5: Adapted models of stakeholder involvement.....	44
Table 6: Power/interest grid for stakeholder prioritisation.....	47
Table 7: Service provider respondents.....	68
Table 8: Potential participants	70
Table 9: Research participants.....	73

List of Figures

Figure 1: The commissioning cycle	7
Figure 2: Relationships within the NHS	11
Figure 3: Phases of data collection	14
Figure 4: CCG commissioning structure: performance management and guidance.	20
Figure 5: CCG levels of engagement	23
Figure 6: Levels of alcohol problem	27
Figure 7: Arnstein's ladder of citizen engagement.....	42
Figure 8: Rungs of citizen engagement.....	43
Figure 9: The 4 stages of a research strategy	55
Figure 10: The Interpretivist Approach	57
Figure 11: Commissioning structure (February- March 2010).....	67
Figure 12: Commissioning structure (April 2011)	69
Figure 13: Proposed adaptations to Arnstein's ladder.....	159

List of Acronyms

AA	Alcoholics Anonymous
ANARP	Alcohol Needs Assessment Research Project
CCG	Clinical Commissioning Group
CSU	Commissioning Support Unit
DANOS	Drug and Alcohol National Occupational Standards
DH	Department of Health
DPH	Director of Public health
ENHS	English National Health Service
GP	General Practitioner
GPFH	General Practice Fundholding
GPwSI	General Practitioner with Special Interests
LA	Local Authority
MoCAM	Models of Care for Alcohol Misusers
NEPHO	North East Public Health Observatory
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NTA	National Treatment Agency
PBC	Practice Based Commissioning
PCG	Primary Care Group
PCT	Primary Care Trust
PHB	Personal Health Budget
PHE	Public Health England
PPI	Public and Patient Involvement
SBI	Screening and Brief Intervention
SHA	Strategic Health Authority
SMART	Self-Management and Recovery Training
TPP	Total Purchasing Pilot
UK	United Kingdom
WCC	World Class Commissioning
WHO	World Health Organisation

Chapter 1 Introduction

1.1 Chapter overview:

This doctoral thesis presents a qualitative study of stakeholder involvement in alcohol treatment commissioning in the North East of England. The research took place between 2009 and 2014 a uniquely transformational period in the English commissioning landscape. At the beginning of the research, commissioning teams were still engaged in embedding the principles of the World Class Commissioning (WCC) policy published in 2007. The arrival of the coalition government in May 2010 resulted in a series of substantial changes to commissioning. Policy changes included the abolition of WCC, the abolition of Primary care Trusts (PCTs), the transfer of commissioning responsibility to Clinical Commissioning Groups (CCGs) and local authorities; and finally significant changes in job specifications due to the commissioners remit transforming from focusing purely on alcohol commissioning to encompassing an entire public health portfolio inclusive of drugs, alcohol, smoking, obesity and sexual health.

The research investigated stakeholder perceptions of their involvement in the commissioning process over the course of this period of change, with a focus on the perceived impact of stakeholder involvement on the organisation, design and delivery of alcohol services. First this chapter provides an overview of the background and context to the research, including the concepts that underpin the research conducted in this thesis and a justification for the focus on alcohol as a key commissioning case study. This consists of introducing alcohol terminology and contextualising the extent of the current alcohol problem before considering commissioning in the English NHS (ENHS) and more recently the local authority. This is followed by a brief outline of what constitutes public health before considering how the involvement of stakeholders can broaden the scope of the commissioning process. The chapter continues to outline the research question, objectives and design, and finishes with an overview of the structure of the thesis.

1.2 Alcohol

In recent years the extent of alcohol related harm has become a matter of significant social, political and academic concern (Centre for social justice 2013). Despite only a

minority of the population being classified as having an alcohol problem, the majority are affected or in advertently witness the consequences of excessive alcohol use (Rossow and Romelsjo 2006). This may occur in the form of vomit on the street, an innocent bystander being caught up in a street brawl or a fatality caused by a drunk driver to name a few. No other public health issue has consequences that are as far reaching as alcohol; therefore it is an interesting and relevant topic to study. Whilst alcohol services are commissioned along the entire spectrum from preventative and educative interventions through to residential rehabilitation this thesis focuses predominantly on alcohol treatment service provision and the 'heavy end' of treatment.

When considering alcohol research, complex terminology is used and various terms have been used to categorise alcohol users with similar behaviours in an attempt to build a clearer sociological picture of alcohol use. The term 'abuse' or 'misuse' are often interchangeably used to explain heavy alcohol use. However, these terms are unsatisfactory concepts within a scientific approach because they involve value judgements. Due to the ambiguity these terms elicit, harmful drinking (A pattern of alcohol consumption that is causing mental or physical damage) and hazardous drinking (A pattern of alcohol consumption that increases someone's risk of harm) (NICE 2010: 48) were introduced in ICD-10 classification (WHO 2011). The term addiction was replaced by the term 'dependency' by a World Health Organisation (WHO) expert committee in 1964 (WHO 2011) due to the exaggerated stereotyping that tends to be associated with these terms (although 'addiction' is still referred to widely). Further classifications include the binge drinker or heavy episodic drinking, defined as "drinking heavily in a short space of time to get drunk or feel the effects of alcohol". Binge drinking has been further defined as drinking "more than double the lower risk guidelines for alcohol in one session" (NHS Choices website 2012) this would translate to consuming eight units or more for men and six units or more for women in a single session. The controlled/social drinker has become a term used widely to portray the use of alcohol for pleasure or leisure, with terms such as 'occasionally', 'in moderation' and 'within sensible limits' being attributed to this category of alcohol users (McGraw-Hill 2002). Due to the variety of terms used to refer to and describe alcohol use the scope for confusion is vast. In an attempt to clarify categories of drinkers and be able to identify individuals whom could benefit

from treatment interventions, the Models of Care for Alcohol Misusers (MOCAM) document provided guidance as to how to measure the level of severity of alcohol use (Department of Health 2006c) as shown in table 1.

Consumption	Safe weekly consumption	Safe daily consumption	Binge Drinking	Hazardous Drinking	Harmful Drinking
Men	< 21 units	3-4 units	8 units per day	22-50 units per week	≥50 units per week
Women	< 14 units	2-3 units	6 units per day	15-35 units per week	≥ 35 units per week.

Table 1: Alcohol consumption levels

Furthermore, four main categories of alcohol misusers have been identified; the classifications were dependant on the level of alcohol consumed, the context of its use, the seriousness of problems associated with the use of alcohol and the severity of dependency as identified in table 2.

Category of Alcohol misuse	Definition of associated problems and severity of dependence
Hazardous Drinkers	A pattern of substance use that increases the risk of harmful consequences for the user
Harmful Drinkers	A pattern of use which is already causing damage to health. The damage may be physical or mental
Moderately Dependant	This category includes a variety of types of problem and range of severity.
Severely Dependant	Have a wide range of alcohol related problems, including significant alcohol withdrawal and habitual daily alcohol use.

Table 2: Categories of alcohol misuse

Recent research has shown that alcohol is the fifth greatest risk to public health in developed countries such as the UK(Lim, Vos et al. 2012). From a national perspective within the UK, it is estimated that one quarter of the adult population are adversely affected by alcohol, 8.2 million people have an alcohol use disorder, 1.1 million are alcohol dependant(Room, Barbour et al. 2005, Department of Health 2005d)and it was estimated that in England, in 2011 there 5,792 men and 2,956 women whose deaths were related to alcohol(Office for National Statistics 2013). Furthermore, within the UK the number of alcohol-related deaths has doubled in one

generation from 4,023 in 1992 to 8,748 in 2011 (University of Stirling 2012). The total cost of alcohol related harm to society is estimated to be £21 billion, with £3.5 billion of those costs being attributed to the NHS alone (Public Health England 2013). In response to these figures government have allocated an estimated £217 million to spend annually on alcohol treatment provision. A body of evidence has emerged in relation to the causes of problem drinking and how to reduce them (Alcohol Concern 2009). Evidence states interventions aimed at reducing and treating alcohol related problems “will result in cost savings that exceed the investment made”(Wood 2003), furthermore, it has been identified that for every £1 spent on treatment, the public sector will save £5 (Department of Health 2005d). Recent research suggests that the reduction of problems and the associated harm with problematic drinking is an increasingly valid public health focus (Rehm J 2013).The problem has worsened in recent years and the past 30 years have witnesses some significant changes in alcohol consumption patterns. Despite the overall amount of alcohol consumed remaining stable, there has been an increased prevalence of both drinking at hazardous levels and heavy episodic drinking. It is suggested that a number of contributory factors such as relative affordability, availability and accessibility of alcohol have played a role on these increases in consumption (Rabinovich, Hunt et al. 2012). It is these factors alongside changing social norms relating to the perceived *acceptability* of certain drinking behaviours that have profound consequences for public health(Seaman P and Ikegwuonu T 2010). In the short term there is an increased risk of morbidity and mortality whilst there is also the longer term implication for the development of problematic drinking practices in later life(Patrick CH 1952).

1.2.1 Alcohol use in the North East

In the North East region, the case study area considered in this thesis, it has been estimated that alcohol related harm costs the region between £950 million and 1 billion annually (South Tyneside Alcohol Harm Reduction Strategy Group 2007). Further, there is a significantly higher directly standardised mortality rate in the North East in comparison to the rest of England (Dudzile 2006), with drinkers being more likely to be admitted to hospital, binge drink, and die younger than their southern counterparts (Addicted Britain 2006). Yet despite the rising cost of alcohol- related harm in the North East, evidence suggests that service provision for the region’s

heavy drinking remains inadequate. A report by Balance showed that at the end of 2010/11; 9,456 people were being treated in the North East; however this only accounted for approximately 4.7% of dependent drinkers accessing specialist treatment (Balance 2012). This shortfall is perhaps unsurprising, given that the former Primary Care Trusts (PCTs) received criticism, as despite the drive to reduce alcohol related harm, the expenditure in this area did not reflect the increased political focus. In 2006- 07, PCTs spent an average of £600,000 on commissioning alcohol services, equating to “a little over 0.1% of a typical PCT’s total annual expenditure of around £460 million” (Shenker, Sorensen et al. 2009). It has been identified that each year PCTs spent £197 per dependent drinker in comparison to £1,744 per dependent drug user.

In response to the rising problems the North East alcohol misuse statement of priorities was launched in 2007, stating that the aim was to drive down “poor health, crime, disorder and the social and economic harms associated with alcohol misuse” (North Tyneside Strategic Partnership 2008). Despite the increased focus on addressing alcohol related harm and establishing multiagency working, in 2008 it was still apparent that alcohol services varied widely, both in type and degree of provision (NAO 2008). Seven years after the statement of priorities was published the alcohol strategies available in the North East area still aim to address the harms caused by alcohol misuse (Sunderland Partnership 2008, Safer Gateshead 2010, South Tyneside Partnership 2013). One strategy identifies that in an effort to reduce alcohol related harm and reach the stated public health goals, a collaborative effort needs to be made by local stakeholders committed to promoting public health and community safety. The public health goals identified in relation to alcohol were to;

- “Reduce the overall level of alcohol consumption in the population
- Reduce the incidence of alcohol-related illness, injuries and death
- Reduce the incidence of alcohol-related disorder, anti-social behaviour, violence and crime”

(South Tyneside Partnership 2013: 7)

There is clearly a high level of alcohol related harm and an identified need for alcohol treatment interventions within the UK. The development of alcohol policy is further explored in Chapter 3 of this thesis.

1.3 Commissioning in the English NHS

Commissioning is not a new concept within the English NHS having first been introduced as part of a series of changes announced in 1989. Commissioning is “the process of ensuring that the provision of health and care services provided effectively meet the needs of the population” (Department of Health 2009a). However, the term commissioning is ill defined and the terms ‘contracting’, ‘purchasing’, ‘procurement’ and ‘commissioning’ have all been used interchangeably within the NHS lexicon since their introduction in the late 1980s. The term commissioning encompasses a wide range of activities, whereas terms such as ‘procurement’, ‘contracting’ and ‘purchasing’ refer to a specific activity. The NHS provides a working definition of “the act of commissioning resources, particularly, but not limited to the health and social care sector, with the aim of improving health, reducing inequalities, and enhancing patient experiences” (Sobanja 2009: 1). The Department of Health (DH) describes the commissioning process as:

“A complex process with responsibilities ranging from assessing population needs, prioritising health outcomes, procuring products and services, and managing service providers”

(Department of Health 2009a).

This is a similar definition as described by others and there is a consensus that the term is complex, multifaceted and strategic (Wade, Smith et al. 2006, Commission 2008, Peskett 2009, Shapiro 2009, Rivett 2010). The absence of a single agreed definition is a serious problem for commissioning (Wade, Smith et al. 2006). For although the numerous differences in terminology could be seen as a matter of semantics, without a clear understanding and a common agreement of what the term entails, the potential for misunderstanding is considerable and can result in a lack of agreed objectives and purpose which may create confusion and tension among the various stakeholders. When the term commissioning is used within the thesis it refers to the Department of Health definition.

1.3.1 The commissioning process

Commissioning is commonly described as a cyclical process, involving a number of separate but interlinked activities (Department of Health 2007d). Commissioners must ‘police’ the whole system, to ensure that decisions have been effective and work within the complex and changing national agenda (Richardson 2006). Each element of the cycle is sequential and is repeated on a regular basis. Services are continually refined in an attempt to achieve the best outcomes. Each element is of equal importance when commissioning services. Figure 1 provides an illustration of how this process works.

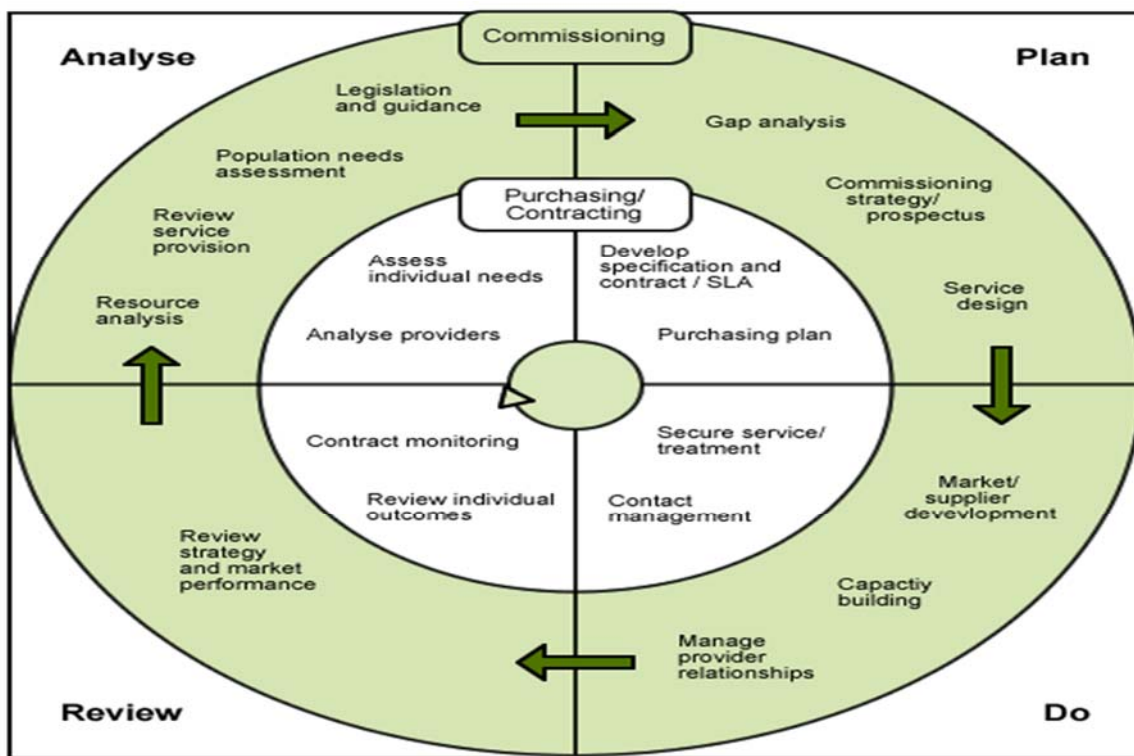


Figure 1: The commissioning cycle

The process includes assessing the needs of a population, responding to the highlighted needs and designing and implementing care pathways around those needs. The ongoing process of assessing need and reviewing service provision can take place at various different levels. Within the NHS this ranges from commissioning on a national level to individual practice or locality commissioning. Regardless of the level of commissioning “purchasing health services is inherently difficult in publicly financed health systems since purchasers are continually faced with the multiple and frequently conflicting explicit and implicit expectations of

politicians, central government officials, managers, clinicians, patients and the public for the health system”(Ham 2008: 119). The commissioning role is likely to become harder within the current financial climate due to the need for the NHS to provide more services for the same due to increasing demand and the greater availability of new, expensive interventions and treatment.

With the cost of health care rising and a rise in demand for services due to an aging population, increases in lifestyle related diseases and available treatment options become more sophisticated and expensive(NHS Confederation 2013, NHS England 2013b)there has in turn been an increased interest in evidence based interventions, efficient use of resources and accountability of the health care system (Baggott 1998). Furthermore, the prevalence of non-communicable disease and multi-morbidities are becoming more common, resulting in long term health consequences and in turn a need for long term treatment and care(Department of Health 2012a). This aspiration for increased efficiency and accountability requires shifting the focus of commissioning from the downstream (i.e. reactive) to the upstream (i.e. proactive),focusing on health promotion and ill health prevention(NHS England 2013b). This is not only much more effective and efficient for reducing our dependence on treatment services in the long-term; it is also much more beneficial for the health of the population(Boyce 2010). In a system where the supply of healthcare will always be exceeded by the demand, rationing mechanisms may be required. Therefore the ability to monitor and prioritise the efficiency of interventions is pivotal to helping to inform commissioning decisions(Williams, Dickinson et al. 2010).

Commissioning structures arising from policy decisions have taken a number of forms including; GP fundholding (1991- 1999), Total Purchasing Pilots (1994- 1999), Practice Based Commissioning (2005-2007), World Class Commissioning (2007- 2013) and most recently Clinical Commissioning Groups and local authority commissioning (2013- present). The connecting theme common to all these initiatives is to utilise the expertise of GPs and clinicians when commissioning services (each of these policy initiatives is discussed further in Chapter 2). General practice and GPs specifically remain the most frequent first point of contact for

patients within the NHS for non-urgent care regarding physical and mental health and wellbeing concerns (Boyce 2010, Department of Health 2013). There are over 36,000 GPs in England (www.indicators.ic.nhs.uk) and in 2008/09 over 300 million GP consultations took place, which has led commentators to assert that GPs are the 'key agents' who have the most frequent opportunity to improve public health (Wirrman and Carlson 2005). It has been suggested that it is more efficient to plan and commission health care at a population level due to the complexity of the healthcare system (Department of Health 2013). Furthermore, clinician involvement in commissioning is reported to result in higher quality of care, better patient experience and a more efficient use of the NHS's resources (Department of Health 2010a).

1.4 Public health

The Wanless Report (2004) provides a useful description as to how the term 'public health' has evolved from being concerned mainly with the prevention of communicable diseases to a much more complex term that takes into account the commonly accepted wider determinants of health including living and working conditions and socioeconomic, cultural and environmental conditions. The deliberate inclusion of this multi-layered dimension highlighted the contribution that all government departments can make to the public's health. Acheson had originally defined public health as "the science and art of preventing disease, prolonging life and promoting health through the organised efforts of society" (Acheson 1988).

The challenge of commissioning for a public health issue presents policy makers and practitioners with long term challenges, which require cross-sector strategic and political leadership, and the expertise and engagement of a range of stakeholders. For example, the design and commissioning of services and interventions to reduce alcohol-related harm does not fit within the remit of any single government department or agency, but spans health, crime and education to name but a few. As a result, commissioning for alcohol interventions often occurs across a variety of different organisations, potentially leading to inefficiencies, gaps and overlaps in provision (Department of Health 2007d). However, despite an identified need for a more collaborative approach to the commissioning of services in public health, a partnership approach is not always reached.

Further, the vast majority of NHS spending is on the commissioning of services for the treatment of ill-health, e.g. hospital care, drugs, primary care etc., with only a relatively small proportion currently dedicated to health promotion and prevention. At the same time, it is well documented that our increasingly unhealthy lifestyles (i.e. increasing levels of obesity, lack of physical activity, increasing alcohol consumption, smoking etc.) will, if unchecked, lead to increasing disease prevalence (e.g. diabetes, cancer, heart disease, liver failure, stroke etc.) in the future (WHO 2013, Royal Society for Public Health 2014). In turn, this will result in an increasing demand on health services, which is unlikely to be financially viable given the current funding situation (Appleby J 2013). The role of public health commissioning is thus of growing importance, with methods of service delivery required to be increasingly efficient and effective. The concept of involvement of stakeholders in the commissioning process is considered below.

1.5 Stakeholder involvement in commissioning

There has been a rising focus on the importance of stakeholder involvement in the organisation, design and delivery of health services in recent years (Callaghan and Wistow 2006, Chisholm, Redding et al. 2007). For whilst, commissioners legitimately hold the power when making decisions regarding which treatment options to invest in, they are also accountable to a wider group of service stakeholders. A stakeholder can be described as “any group or individual who can affect or is affected by the achievement of the organisation’s purpose and objectives” (Cornelissen 2008:42). Stakeholders can be broadly categorised as primary and secondary stakeholders. As defined by Clarkson “a primary stakeholder group is one without whose continued participation the corporation cannot survive” (1995:106) whilst a secondary stakeholder group is defined as “those who influence or affect, or are influenced and affected by, the corporation, but they are not engaged in transactions with the corporation and are not essential for its survival” (1995:107). The number of primary and secondary stakeholders involved within commissioning decisions such as those round alcohol services is substantial. Moreover, the relationships between stakeholders and organisations such as the NHS are not linear in nature but are interdependent, as shown in figure 2.

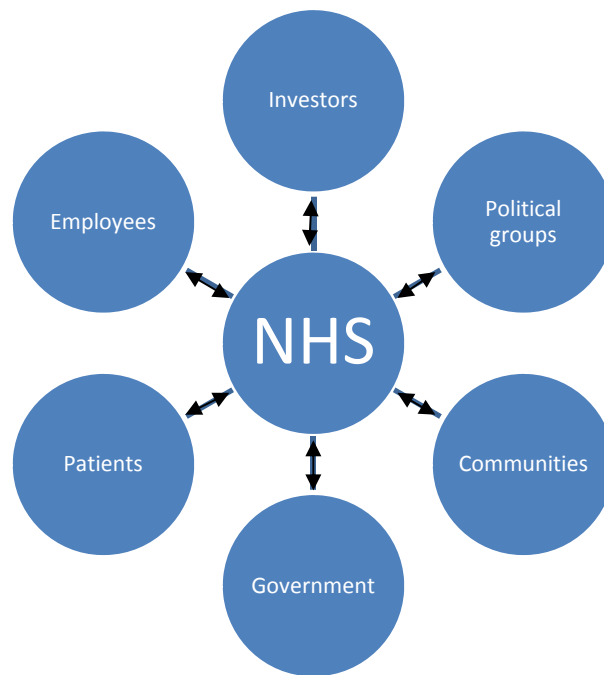


Figure 2: Relationships within the NHS

Given this increasing focus, therefore an important element of the commissioning process is that it is responsive to stakeholders and provides a platform for clinicians, partner agencies and members of the public and patients to engage in consultations to shape the decisions being made. The advantages of stakeholder involvement in health care planning are well documented and include higher levels of accountability due to reflecting the needs of the community in the decision making process, increased support for the resulting services, monitoring the quality of service provision and a more efficient use of scarce resources (Pivik 1997; Nancarrow 2004). Furthermore, it is evidenced that if service users are involved in the planning of services, their commitment to understanding, adhering to and valuing the care they receive is increased (Entwistle and Hanley B 2006, Swainston and Sumerbell 2007). Particular areas of mental health, learning difficulties and women's health have witnessed huge advances in stakeholder involvement (Croft and Beresford 1992, Rowe and Shepherd 2002). The developments that have emerged in stakeholder involvement have been related to various origins; however the anti-psychiatry movement (Barker and Peck 1987, Truman and Raine 2002), the rise of consumerism (Beresford 2000) and the increasing willingness of the public to challenge expert knowledge have been widely influential (Charles and DeMaio 1993). As stated by Bowling, the rationale for increasing stakeholder involvement is

that “while experts within medical and health care specialities and professions can advise on clinical facts in propriety settings, only members of the community can express community health values”(Bowling 1992). As Bowling recognizes each group identified, inclusive of medical and health care specialists, professionals and members of the community are all a form of stakeholder. Stakeholder involvement amongst these groups facilitates an exchange of expertise from varying perspectives.

1.5.1 Stakeholder involvement in alcohol treatment

When thinking about alcohol service users and their involvement in their own care, it becomes apparent that the scope and degree of alcohol use/misuse and the underlying reasons for doing so are multifarious, rendering it problematic for a sole identity to be attributed to ‘alcohol service users’. Furthermore, there are likely to be many alcohol users who would not consider themselves to have a problem and who would not countenance attending specialist services. The potential scope for a substantial mixture of alcohol users, inclusive of hazardous, harmful, dependant and binge drinkers further emphasises the limitations of classifying service users as a homogenous group. This in turn, highlights the challenges of obtaining perspectives which incorporate the views of such a diverse group of individuals.

Guidance such as the substance misuse advisory service commissioning standards and Drug and Alcohol National Occupational Standards (DANOS) identify service users as key stakeholders and advocate that they should be at the heart of organisations. However, far from being a uniform approach, when obtaining service user views, the methods of engagement and response to stakeholder involvement within agencies is variable and a distinction is made between ‘reactive’ and ‘pro-active’ involvement(Ridley and Jones 2002). Reactive involvement occurs when services ascertain responses to an activity or a service. Alternatively, pro-active involvement ensures that service users become involved in defining needs and making proposals for new or improved services (Mullen and Spurgeon 2000). Whilst either forms of involvement highlight progression, only pro-active involvement signifies genuine participation and has the ability to adapt services in response to the service users’ perspective.

From the perspective of an individual patient, if empowerment is embraced within the healthcare environment it can impact upon their overall health. This can occur by enhancing an individual's sense of self-efficacy, "thus encouraging them to take more responsibility for reducing risk factors and preventing ill health"(Coulter 2006:27). From a commissioning perspective, stakeholder involvement is reported as increasing the quality of services (Crawford 2003), achieving value in commissioning decisions and reducing the levels of health inequalities (Martin 2009). However, despite the multitude of policy documents that commend involvement of stakeholders, limited and inconclusive evidence exists regarding the impact of participant involvement on both services and the individual (Crawford 2002, Hubbard 2004, Nilsen 2006, Wallcroft 2011).

1.6 Justification for the research/purpose of the study:

Despite the recognition of the importance of commissioning and the plethora of published critiques of past commissioning policies, there is minimal academic research into alcohol commissioning within the context of health and social care. Therefore, this thesis will seek to examine whether stakeholders perceive they are involved in the commissioning process surrounding alcohol service provision and identify whether they perceive their involvement impacts on the organisation, design and delivery of frontline alcohol services.

1.7 Research questions:

This research aims to expand academic knowledge of how stakeholders influence the commissioning of alcohol services within the NHS. The research question being answered within this thesis is: Using alcohol services as a case study, who are the stakeholders that are involved in the commissioning process and how do they perceive their involvement in the design, organisation and delivery of frontline alcohol services?

The research objectives are:

- To explore who is involved in the commissioning of alcohol treatment across a North East region of England and what influences the decisions that are made.

- To investigate the perceived impact of stakeholder involvement on the organisation, design and delivery of frontline alcohol services.
- To identify the lessons learnt from the perspective of the stakeholders interviewed and establish how they can be used to inform future commissioning practice in relation to alcohol treatment.

1.8 Research Design:

In an attempt to obtain a holistic understanding of the commissioning process a case study approach was adopted using qualitative methodology. Semi structured interviews and focus groups were held to obtain multiple perspectives of stakeholders. Three phases of data collection took place between February 2010 and July 2014. As Figure 3 shows, participants included alcohol commissioners within the PCT/local authority (LA), alcohol service providers, general practitioners and alcohol service users located within the geographical boundaries of NHS X. Thematic analysis was undertaken to present a rich description of stakeholders' perceptions of their involvement in the commissioning process. The rationale for the methodology and methods chosen within the thesis is expanded on further in chapter 4.

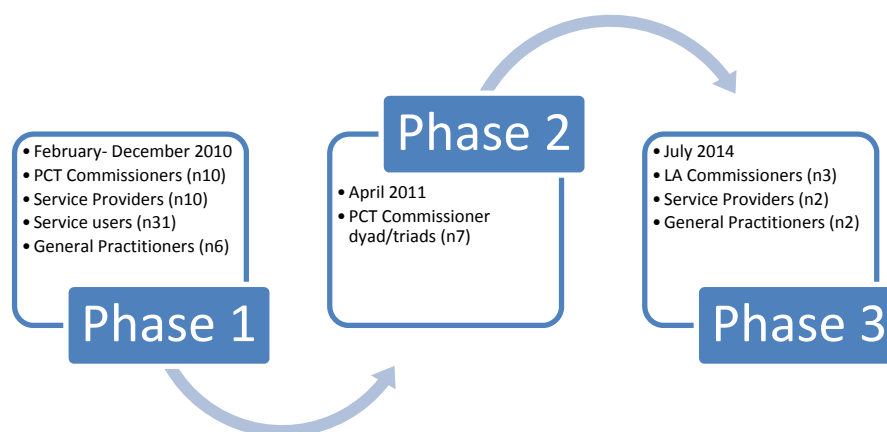


Figure 3: Phases of data collection

1.9 Overview of thesis chapters:

The remainder of the thesis is structured as follows: Chapter 2 provides an in-depth exploration of the background and contextual information regarding commissioning and alcohol. This is followed by a review of the pertinent academic and research literature in Chapter 3 surrounding stakeholder involvement in health care. The literature review provides an overview of the complexities of defining stakeholders,

the national policy context and associated benefits of involving stakeholders in the commissioning process. This is followed by a critique of the models of stakeholder involvement already in existence before considering the barriers that are associated with stakeholder involvement.

Chapter 4 outlines the methodology and methods of research adopted to study the complex and multifaceted subject area of commissioning alcohol treatment interventions. The chapter outlines the theoretical perspective taken throughout the research and the research design used to meet the objectives. The methods chosen to research the topic are identified, alongside an explanation for using qualitative methods. In relation to each group of participants, the methods of data collection and analysis are identified, described and justified.

Chapter 5 and 6 present the findings from the data collection.

Chapter 7 presents a detailed discussion of the results obtained throughout the course of this research. It provides an overview of the key literature and presents an analytical discussion of the overarching themes occurring throughout chapters 5 and 6. Furthermore this chapter provides a conclusion to the thesis and acknowledges limitations of the research, implications for policy and areas of interest for future research.

These seven chapters form the main body of the thesis, which is then followed by a full bibliography and a series of appendices.

Chapter 2 : Alcohol Commissioning- Background and Context

The chapter focuses on the Health and Social Care Act 2012 which was implemented in April 2013. The commissioning section explores the impact that the Act has had and makes connections between previous commissioning efforts and the state of commissioning currently in regard to the new public health system.

2.1 A brief overview of Commissioning Policy

Commissioning has had a rather chequered history within the NHS and structural reforms have been continuous. These have had implications for who holds commissioning responsibility since it was introduced as part of a series of changes announced in the 'Working for patients' white paper under the conservative government (Department of Health 1989). A key change amidst all of the reforms in England since the early 1990s has been the aim of creating a 'primary care led NHS' and moving towards a truly patient led service (Department of Health 1989, Department of Health 1997, Craig 2002).

The commencement of the GP Fundholding (GPFH) scheme in 1991 enabled GP practices to opt in and hold a devolved 'real' budget from which to purchase some services, including community, outpatient and elective care. Incentives such as being able to retain any budget saving were offered and evaluations of the scheme show that waiting times reduced (Dowling 2000, Propper 2002), along with reductions in prescribing costs (Maxwell 1993, Whynes 1995, Robinson 1996, Lewis 2004). Furthermore, evaluations showed a reduction in the lengths of hospital stay and delays in transfers of care and an increase in the provision of community services, all of which maximised the potential for savings in practices (Nuffield Trust 2010). However, despite these positive outcomes outlined, fundholding schemes were accused of creating a two tier system for patients, with patients registered with fundholding practices experiencing better access to hospital care than those registered with non-fundholding practices (Le Grand, Mays et al. 1998). Furthermore, resources rarely shifted from hospital budgets, patient satisfaction reduced and there were increased management and transaction costs (Mannion 2005). Opposition to the scheme was expressed by many GPs as it was believed that some fundholding practices prohibited unhealthy patients (e.g. patients with certain chronic care) and therefore expensive patients from registering (Brereton and Vasoodaven 2009). It

was also felt that some practices 'cherry picked' patients perceived to be low cost (Shapiro 2009) which resulted in concerns over equity and access to services. GPFH was a central component introduced to create the primary care led NHS envisaged in the conservative government's strategy (Baggott 1998). However, a report by the Audit Commission (1996) found little evidence to suggest that GPs were actively involving patients in the decision making process. Furthermore, evaluations of the GPFH scheme only focused on process and outputs such as waiting times rather than health outcomes (Audit Commission 1996), so direct comparisons of impact on patients' health between fundholding and non-fundholding practices could not be made (Cowton and Drake 1999). The quality of evidence available to formally evaluate GPFH lacked rigour and it has been stated that, "studies tended to be small scale, piecemeal and lack adequate controls" (Mannion 2005: 2).

The introduction of Total Purchasing Pilots (TPPs) in 1994 extended the GPs' purchasing power and budgets were enlarged to a wider range of services, inclusive of elective and emergency services. Again benefits were experienced, such as lower waiting times, lower admission rates, reductions in growth of prescribing costs and better collaboration between GPs, the extra budget also resulted in improvements in primary care services and community based alternatives to hospital care (Mannion 2005). TPPs were evaluated nationally (Goodwin, Mays et al. 1998) and the conclusions were that they proved expensive to operate and the anticipated changes were not as significant as hoped (Collins, Green et al. 2000) as resources rarely shifted from hospital budgets and there was a lack in transformational shift regarding the volume and location of hospital services. The abolition of GPFH and the establishment of 481 Primary Care Groups (PCG) in 1999 signalled a continual commitment to move towards a primary care led NHS (Ham 1999). However, the life of PCGs was short lived as they progressed to trust status and became 303 Primary Care Trusts (PCTs) in 2002, shifting the responsibility again this time into primary care (Klein 1998). The progression to PCTs signalled an attempt to develop greater sensitivity to local needs and a way of attempting to achieve greater independence (Wilkin 2001).

Under the PCTs, a new GP commissioning structure was introduced in 2005 called Practice Based Commissioning (PBC). Practice based commissioning was introduced at the time of the 'shifting the balance of power' reforms which New Labour introduced in response to charges of their approach to managing the NHS being over-centralised and characterised by too much micro-management. It was designed to engage primary care clinicians in the commissioning process. Indicative budgets were devolved to practices (Curry 2008) whilst PCTs continued to hold responsibility for funding. PBC aimed to provide clinicians with a budget allowing them to become more responsive to patients' needs and to increase the range of services available to patients; in turn acknowledging the importance of choice to both empower patients and drive forward the quality of services (Department of Health 2004b). In the white paper 'Our health, Our care, Our say' (Department of Health 2006b) PBC was described as pivotal to shifting care away from hospitals and into the community setting. However, the widespread clinical engagement that was anticipated in policy did not occur and there was a lack of progress (Smith 2004). This was attributed to a number of factors including a lack of incentives for clinicians to get involved, only an indicative budget to work with, poor data to inform commissioning decisions, and a complex system that required PCT approval of PBC plans. There was limited advancement of this scheme and where major achievements occurred, this was generally due to a few highly motivated GPs (Smith 2004, Curry 2008).

In parallel, the World Class Commissioning (WCC) programme was launched in December 2007. Its purpose was to strengthen PCTs commissioning capacity and capability in order, borrowing a phrase from WHO, to 'add life to years and years to life' (Department of Health 2007c). The WCC policy signified a concerted attempt to address the problems associated with previous under achievements in commissioning and focused on investing in the skills and competencies necessary for the commissioning task. The policy provided a framework of 11 competencies which if achieved would lead to improvements in commissioning, and thus, health outcomes and health improvement (Department of Health 2007e). Nevertheless, in the 2010 House of Commons Health Committee report it stated that WCC was no more than a 'box ticking' exercise. Furthermore, a study by McCafferty et al (2012:

42) identified that “the performance management structures of WCC created an undue focus on the assurance and assessment process which had, in turn, distracted efforts from improving commissioning processes, and improvements in health outcomes and population health that were initially intended”. Despite it being identified that there was a “sizeable gap between what was being delivered and the standards expected in the WCC programme”(House of commons health committee 2010: 26) the WCC programme was present to varying degrees within PCTs until the introduction of CCGs in 2013.

The 2010 NHS White Paper ‘Equity and Excellence: Liberating the NHS’ proposed: putting patients and the public at the heart of the NHS, improving health outcomes, increase levels of autonomy, accountability and democratic legitimacy and cutting bureaucracy and improving efficiency(Department of Health 2010a). The focus of the reforms was to reduce levels of bureaucracy currently experienced by shifting the power from government to frontline clinicians and patients. Furthermore, the emergence of the coalition government in May 2010 led to the most recent radical changes resulting in the abolition of PCTs and Strategic Health Authorities (SHAs) and the establishment of Clinical Commissioning Groups (CCG). The new commissioning structure highlighting the performance management and guidance for CCGs is shown below in figure 4.

Commissioners: performance management and guidance

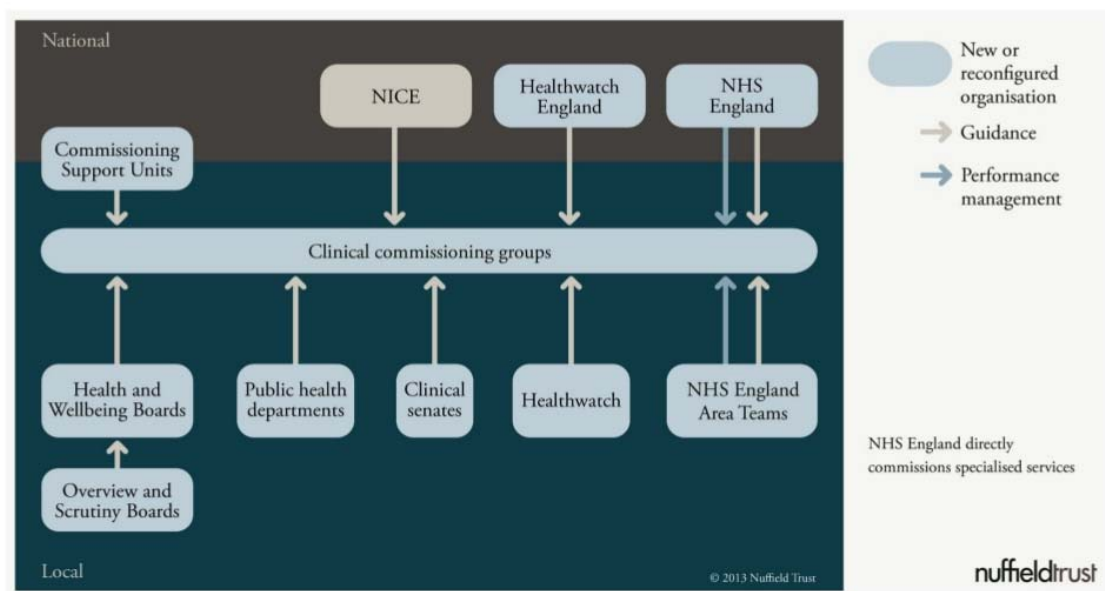


Figure 4: CCG commissioning structure: performance management and guidance.

CCGs are groups of general practices that work together to plan and design local health services in England. This new structure placed GPs and clinicians in charge of shaping services which would enable NHS funding to be spent more effectively. Their purpose is to “Commission safe, high quality and sustainable services within available resources”(NHS England 2013a: 1). In an attempt to place commissioning power and responsibility in the clinician’s hands, the vast majority of the NHS England’s budget (£63.4 billion) for local commissioners 2013-1024 was allocated to CCG’s when they became statutory, accountable organisations on 1st April 2013 (Heath 2014). CCGs are responsible for commissioning urgent and emergency care, elective hospital care, community health services, maternity and new-borns and mental health and learning disability services within their locality (NHS England 2014). Commissioning support units (CSU) were introduced to assist CCGs in carrying out the more practical aspects of their commissioning role. CSUs can provide support in a number of areas including service redesign, information and data analysis and contract negotiation.

Alongside the introduction of CCGs, further key agencies have been introduced surrounding commissioning roles and responsibilities. NHS England has responsibility for commissioning primary care, specialised healthcare services, health services for serving personnel and families in the armed forces and health services for people who are in prison or other secure accommodation (Nuffield Trust 2013). In addition there is an extended role for local government as PCT responsibility for public health was transferred to local authorities. Each local authority has taken on the responsibility of joining up the commissioning of NHS services, social care and health improvement. A new executive agency of the department of health, Public Health England (PHE), supports the system and provides overall national- level leadership(NHS Confederation 2010). The main functions of PHE include health protection, health improvement, knowledge and information and operations. Clinical senates are a further key agent within the new commissioning structure. Clinical senates are advisory groups consisting of multi professional experts from across the health and social care field whom provide strategic advice and guidance to commissioners. The purpose of these advisory groups is to assist commissioners to make the best decisions about healthcare for the populations that they represent (NHS England 2014). As identified above, commissioning structures have witnessed significant changes that are likely to make things more complex, fragmented and harder for stakeholders to comprehend and navigate.

As this review of health policy illustrates; the current format of involving clinicians in commissioning is not new and elements of them have been tried previously albeit in various formats and on a smaller scale in the form of GPFH, PBC and WCC. There are connecting themes among the present commissioning structure and its predecessors. General practice and GPs specifically remain the most frequent first point of contact for patients within the NHS and are therefore perceived to be a 'key agent'(Boyce 2010).The connecting theme of all these initiatives has been to utilise the expertise of these 'key agents' when commissioning services. The rationale behind utilising the skills of GPs and other frontline clinicians is that they have the potential to be ideally positioned to lead on commissioning on public health. As a

group, clinicians are felt to have an understanding of the needs of their patients and their local communities (<http://www.gov.uk>). However, it is the conflict between caring for the individual versus addressing wider population health goals that creates potential problems. Policy-makers advocate community engagement to tackle the wider social determinants of health, but it is not clear that this is something that the majority of GPs are equipped or motivated to do (Hutt and Guilmour 2010).

Evidence suggests that when clinicians are involved in commissioning it can result in “higher quality care, better patient experience and more efficient use of NHS resources”(British Medical Association 2012: 4). With clinicians often being viewed as advocates for patients and gatekeepers into care, the potential of clinicians to develop care pathways, strengthen primary care services and engage in decision making on behalf of patients has the potential to be considerable. As the brief review of commissioning approaches has highlighted, policy has attempted to achieve a primary care-led NHS via a number of clinically led initiatives, each achieving varying degree of success. The problems experienced historically suggest that difficulties may still arise in relation to GP commitment, levels of accountability and the limited power to influence commissioning decisions(Prowle 2010). However, some significant differences are present between previous commissioning structures and the current CCGs.

In previous structures, GPs had a choice as to whether they became involved in commissioning activities as participation was voluntary. The outcome of this resulted in variable levels of engagement across the country. A problem was that PCTs could be stripped of their budget; this however presented little threat to GPs unwilling to engage as arguably the budget was notional anyway and did not afford them much freedom(Smith 2009). The disparity in the willingness of GPs to be involved in the commissioning process has been recognised and significant challenges exist in trying to engage more than an enthusiastic minority of GPs in holding real budgets for commissioning (Heron and Campbell 2010). Unlike previous systems in which GP had the choice to ‘opt in’, all GPs in England are legally obliged to become members of CCGs. GP-led commissioning in the new guise is a universal system attempting to involve all practices. However, regardless of the legal position, a study

by the Kings Fund and Nuffield trust shows that in 2014 out of the 279 GPs interviewed approximately 23% felt moderately engaged and only 12% of GPs felt highly engaged as illustrated in figure 5.

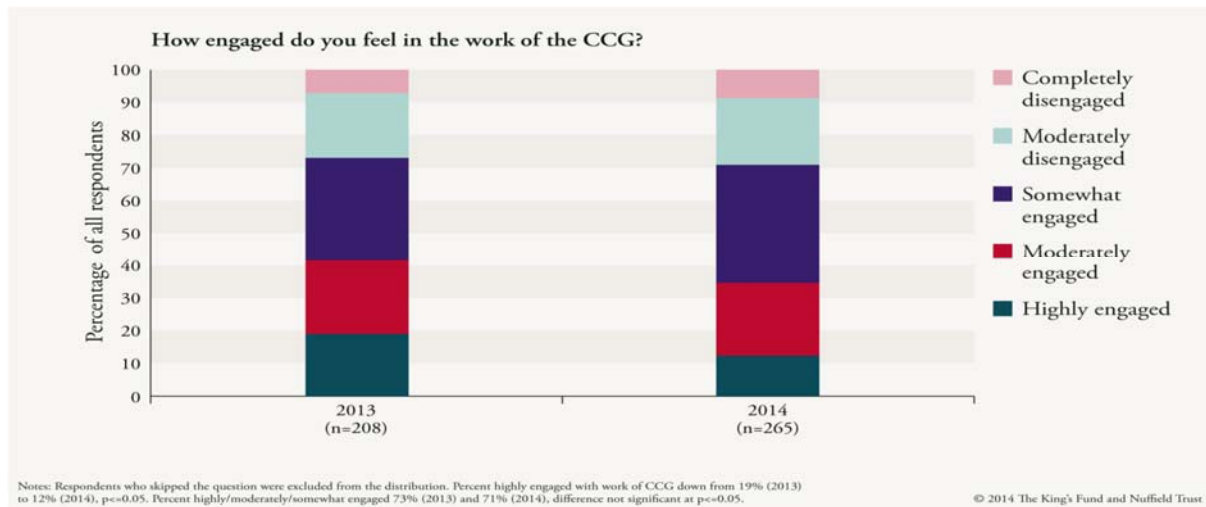


Figure 5: CCG levels of engagement

(Robertson 2014)

A common criticism of previous policies was that GPs only had a devolved 'real' budget or an indicative budget resulting in limited motivation for individuals to become involved in the commissioning process due to a lack of autonomy and high levels of bureaucracy. In contrast CCGs hold real budgets and have the flexibility to reinvest any savings that they generate into patient care, therefore enhancing the incentive to commission services efficiently. Furthermore, in addition to holding a real budget, CCGs have the responsibility for improving outcomes for patients. They are held accountable for their actions having to evidence that they are getting the best value for money from the budget available to them. Potential dilemmas may arise as GPs take on multiple roles as commissioners, primary care providers and the providers of specialist and community based services. Indeed, a 2013 study in the British medical journal stated that "9% of GPs declared a conflict of interest through a family member" and also "36% of the 1,179 GPs involved in the study who are in executive positions on boards- have a financial interest in a for-profit health provider beyond their own practice"(Lacobucci 2013: 22). The potential for conflicts of interest to arise has to be acknowledged and in order for a high level of public trust in their GP to be maintained this potential conflict will have to be minimised via robust accountability structures (Oswald and Cox 2011).

GPs face a number of complexities within the commissioning role and evidence spanning nearly 20 years acknowledges that whilst there has been some modest success in reducing waiting times and prescribing costs and increasing the provision of community services; previous structures have also had limited success in influencing hospital efficiency and it is in this area that most NHS expenditure occurs (Nuffield Trust 2010). Therefore, CCGs need to improve significantly in this area of commissioning if they are to be more successful than their predecessors. In order to successfully do this, it will involve CCGs stimulating “the primary and community care offer; emphasising prevention and early innovation; and being constructive and rigorous in the management of contracts with providers”(NHS Confederation 2013: 2). In addition, there is a need for transformation with regard to how public health services are commissioned. This is due to the rising demand for services due to an aging population, increases in lifestyle related diseases and available treatment options becoming more sophisticated and expensive(NHS Confederation 2013, NHS England 2013b).Furthermore, the prevalence of non-communicable disease and multi-morbidities are becoming more common, resulting in long term health consequences and in turn a need for long term treatment and care(Department of Health 2012a). GP commissioners have to respond to these challenges by becoming more responsive to need, spending NHS funds more effectively and being held accountable for their actions.

This section has illustrated an ever changing system in relation to commissioning. For the impact of a policy initiative to materialise it takes time and the permanent reform evident in commissioning has meant that there has never been an opportunity for one policy to get sufficiently embedded before a further change is instigated. Due to constant reorganisations, commissioning has not had a chance to mature as a function in its own right(Klein 1998, Le Grand 2002, Ham 2007). Each reconfiguration and commissioning policy initiative over the last 20 years has been intended to produce ‘stronger commissioning bodies’ that would result in more effective services over the long term(Healthcare Commission 2008). However, it has been argued that with each reconfiguration “organisational intelligence gets lost or forgotten, and progress stalled, when energy is focussed on restructuring”(Woodin and Wade 2007: 6).

2.2 Commissioning of Alcohol Services

Alcohol commissioning arrangements have also been subject to substantial change and as part of the public health reforms the National Treatment Agency (NTA) was abolished in April 2013 and its functions transferred to Public Health England (PHE). Since April 2013, local authorities have become responsible for improving the health of their local population and this includes the responsibility for reducing drug and alcohol misuse.

Alcohol is a significant risk to public health and the harmful use of alcohol contributes significantly to premature deaths and disabilities. On a global level alcohol is the fifth leading cause of morbidity and premature death following high blood pressure, tobacco smoking, household air pollution from solid fuels and a diet low in fruits (Lim, Vos et al. 2012). The International Classification of Disease Version 10 (ICD-10) causally links alcohol to over 230 disease codes (Rehm, Mathers et al. 2003; Rehm, Mathers et al. 2009). These classifications are inclusive of diseases in which alcohol is a necessary cause such as alcoholic liver disease and alcohol-induced pancreatitis and those which are alcohol attributable such as cardiovascular disease and diabetes (Poschl and Seitz 2004). Furthermore, alcohol consumption is related to 60 disease conditions, including mental and behavioural disorders, cancers, lung diseases, reproductive disorders and pre-natal harm (Anderson and Baumberg 2006, English, Holman et al. 1995). The demographic characteristics of drinkers and the socio-economic context in which alcohol is consumed also influences health outcomes. Statistics confirm that the disease burden is greatest in socio-economically deprived and/or marginalised people (Rehm, Mathers et al. 2009) and men consistently have higher rates of alcohol-related deaths and hospitalisations than women ([Alcohol-Related Disease Impact \(ARDI\)](#)). The levels of high risk drinking behaviors have increased over the past thirty years. Factors such as affordability, availability and accessibility of alcohol have contributed to these increases in alcohol consumption (Rabinovich, Hunt et al. 2012). The harmful effects of excessive alcohol use is well documented (House of Commons Health Committee 2010, NHS Confederation 2010) and the impact on physical, psychological and social health of individuals and their communities is evident. In addition, there are rising

costs associated with alcohol to the NHS, the criminal justice system, social care and the wider economy. The total cost of alcohol related harm to society is estimated to be £21 billion, with £3.5 billion of those costs being attributed to the NHS alone (Public Health England 2013).

Epidemiological data demonstrate that dependent level alcohol consumption represents a much smaller proportion of the drinking population in comparison to hazardous and harmful drinkers. Resulting in the preventive paradox, which observes that the large number of hazardous and harmful drinkers contribute to more alcohol-related problems at a population level than do the small number of individuals experiencing alcohol dependency (Weitzman and Nelson 2004). It has been argued that: “the greatest impact in reducing alcohol-related problems at a population level can be made by reducing alcohol consumption in hazardous and harmful drinkers, rather than focusing on the most extreme or heaviest drinkers”(House of Commons Health Committee 2009: 102). Trends in alcohol consumption patterns are significant for health service provision as empirical evidence shows that the preventive paradox is most pronounced in populations where heavy episodic drinking (commonly known as binge drinking) is a common component of hazardous or harmful drinking (Rossow and Romelsjo 2006, Poikolainen, Paljarvi et al. 2007). However, the different levels of alcohol problem have to be recognised (identified in figure 6)and it needs to be acknowledged that individual drinkers may move between categories of alcohol problem over time, and the boundaries between categories are not clear-cut.

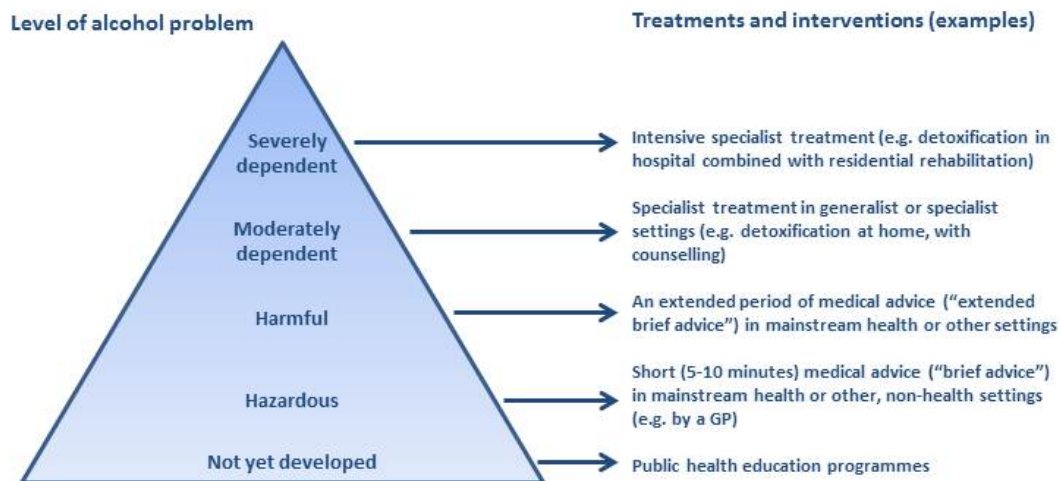


Figure 6: Levels of alcohol problem

When alcohol is consumed at a dependent level it is associated with major physiological consequences and life impairment inclusive of the inability to control use, withdrawal from and tolerance to alcohol (World Health Organisation 2007). Recent figures have suggested that an estimated 1.6 million people may have some degree of alcohol dependence (Public Health England 2013). In spite of the complications associated with dependent alcohol use it has been demonstrated by Rehm and Roerecke, that heavy (though not necessarily dependent) use is responsible for the majority of alcohol related mortality and morbidity (2013).

The growing recognition of both the harmful effects of alcohol consumption, and the rising associated costs (World Health Organisation 2009), have ensured that responding to alcohol-related harm has become a major public health priority in recent years, both internationally and within the UK (World Health Organisation 2011.). However, despite the impetus to address alcohol-related harm, alcohol is not a new concern, with the UK government identifying alcohol-related harm as a problem and declaring its intention to tackle alcohol use over a decade ago in publications including, 'Saving lives: Our Healthier Nation' and the 'NHS Plan'(Department of Health 1992, Secretary of State for Health 1999). The Alcohol Harm Reduction Strategy for England was published a decade ago in 2004 (Cabinet Office 2004) in an attempt to implement the strategic approach required to address levels of alcohol related harm. This policy provided the first concerted effort acknowledging that a collaborative approach to this issue was needed to prevent,

minimise and manage alcohol related harm. This policy acknowledged that alcohol related harm is complex and multi causal in nature and a strategic approach with cross-departmental leadership was emphasised as necessary to tackle the growing alcohol problem in England (Shenker, Sorensen et al. 2009). The policy highlighted the predicted scale of excessive drinking, identifying a need for early identification and treatment and placing greater emphasis on law enforcement. A number of criticisms arose regarding the National Alcohol Harm Reduction Strategy, inclusive of concerns that the strategy's main focus was towards reducing levels of alcohol related crime and disorder whilst the issue of public health and societal needs were secondary. A revised alcohol strategy, 'Safe. Sensible. Social', was published in 2007 (Department of Health, Home Office et al. 2007g) which built on the commitments outlined in 2004 and reinforced that alcohol treatment should be seen as a priority with the focus on prevention strategies being less evident.

The first detailed account of the need for and provision of alcohol interventions was published in 2005 in the Alcohol Needs Assessment Research Project (ANARP) which was the first alcohol needs assessment conducted on a national scale in England (Department of Health 2005d). Also of significance was Models of Care for Alcohol Misuse (MoCAM) which was a best practice guidance document, published in 2006 (Department of Health 2006c). The MoCAM document was published as a document to be implemented on a national scale; however it had direct commitments to both the 'Choosing Health' White Paper (Department of Health 2004a) and the Alcohol Misuse Interventions guidance (Department of Health 2005c). MoCAM introduced a four tiered framework providing guidance on the level of intervention to be offered, the tiers of service provision can be seen in table 3.

Tiers of service	Level of intervention
Tier 1	Alcohol related information and advice; screening ; simple brief interventions; and referrals
Tier 2	Open access, non- care planned, alcohol specific interventions
Tier 3	Community based, structured, care planned alcohol treatment
Tier 4	Alcohol specialist inpatient treatment and residential rehabilitation

(Adapted from: Department of Health 2006c)

Table 3: Tiers of alcohol service

The MOCAM document failed to acknowledge the links between alcohol and crime (Shenker, Sorensen et al. 2009) and to tackle the full spectrum of care, failing to incorporate guidance on two core elements of alcohol treatment that of initiation of abstinence and prevention of relapse (Centre for social justice 2007). The problem with both policies is that their approach remains piecemeal and fails to reflect all of the identified needs surrounding alcohol use. A guidance document by Raistrick et al, (2006) the ‘Review of the effectiveness of treatment for alcohol problems’ identified the range of effective evidence based alcohol interventions that individuals should have access to and was produced to inform MoCAM. Regardless of the levels of alcohol consumed a range of interventions exist. From prevention and health promoting interventions aimed at tackling hazardous and harmful drinking to more intensive and specialist treatment for severely dependent drinking (NAO 2008).

The emergence of a coalition government in May 2010 saw the introduction of a new strategy, ‘Reducing demand, Restricting supply, Building recovery: Supporting people to live a drug free life’(HM Government 2010). This policy acknowledged that a joint drugs and alcohol approach is appropriate. It was the first policy to jointly address both alcohol and drugs, although despite it signalling a significant development, the strategy is still referred to as a ‘drug’ strategy and makes minimal references to alcohol within the document. Furthermore, the coalition government announced their intention to review issues of taxation and pricing and proposed to revise current licensing laws (TSO 2011). When the alcohol strategy was published in 2012 (HM Government 2012) it appeared to deliver on early promises to strengthen supply-side controls, comprising greater powers for licensing authorities and the introduction of minimum unit pricing, a potential landmark in British policy (Ward

2012). However, it again focused on crime rather than health and failed to acknowledge the wider impact of excessive drinking on children and families and concerns were raised about the continued influence of the alcohol industry on UK policy formulation (McCambridge 2012).

Alongside the policies, a series of national guidance documents have been published in the UK by the National Institute for Health and Care Excellence (NICE) with each document looking at a specific area of alcohol use, as can be seen in table 4. June 2010 saw Alcohol Use Disorders: diagnosis and clinical management of alcohol related physical complications(NICE 2010) and Alcohol Use Disorders: preventing the development of hazardous and harmful drinking(NICE 2010) being made available. These guidelines were quickly followed in February 2011 by Alcohol Use Disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence(NICE 2011).

Date	NICE guidance	Guidance Summary
June 2010	CG100 Alcohol-Use Disorders: diagnosis and clinical management of alcohol related physical complications	Care of adults and young people (10 years +) who have physical health problems completely or partly caused by alcohol use; Acute alcohol withdrawal Wernicke's encephalopathy Alcohol related liver damage Alcohol related pancreatitis
June 2010	PH24 Alcohol-Use Disorders; preventing the development of hazardous and harmful drinking (Population approaches aim to reduce the aggregate levels of alcohol consumed therefore lowering the whole populations risk of alcohol related harm. Individual approaches aim to make individual people aware of the potential risks they are taking in relation to their alcohol consumption)	Population versus individual approaches and 10 key recommendations for policy and practice - Government policy recommendation 1-3 (price, availability and marketing) - Practice recommendations 4-12 (Licensing, Screening and Brief interventions for adults and young people aged 10 years plus)
February 2011	CG115 Alcohol-Use Disorders: Diagnosis, Assessment and management of harmful drinking an alcohol dependence	Identification and assessment Interventions for alcohol misuse Working with families and carers

Table 4: NICE Alcohol guidelines

When considering alcohol treatment specifically, it was identified that in 2012-2013, 109,683 people received alcohol treatment (Public Health England 2013). There are 4 principles for commissioning that need to be taken into account to ensure that a successful prevention, treatment and care system exists for individuals misusing alcohol. Those principles are:

1. Improving access to early and preventative intervention and to treatment
2. Treatment is recovery orientated, effective, high quality and protective
3. Treatment delivers continued benefit and achieves appropriate recovery orientated outcomes, including successful completions
4. Treatment supports people to achieve sustained recovery

(NTA 2013)

If a whole system approach is taken when commissioning alcohol services it is hoped that it will have a direct impact on domain 1: preventing people from dying prematurely and domain 2: enhancing quality of life for people with long term conditions of the NHS outcome framework (Department of Health 2012b). A whole system approach would include Screening and Brief Interventions (SBI) used to help individuals recognise problems or potential problems related to their alcohol use and help to resolve any ambivalence an individual has regarding their ability to change their behaviour. For individuals drinking at harmful levels or with a mild alcohol dependency, psychological interventions such as Cognitive Behavioural Therapy should be offered. Psychological interventions often take the format of weekly sessions lasting 60 minutes for a period of 12 weeks. Whilst at the opposite end of the spectrum interventions to assist with withdrawal (community based or inpatient assisted withdrawal) and pharmacological interventions such as Acamprostate, Naltrexone and Disulfiram can be offered to individuals with an alcohol dependency (NICE 2011). In addition to the more traditional treatment approaches, the use of mutual aid groups is becoming of increasing interest. The most recognisable being the twelve step fellowship of Alcoholics Anonymous (AA) meetings. However, the introduction of Self-Management and Recovery Training (SMART) has helped to identify that engagement with mutual aid can support better outcomes post treatment discharge. In addition, there is research evidence to show that “substance misuse treatment can improve sustained recovery outcomes (including abstinence) by actively encouraging service users to engage with mutual aid”(ACMD 2013: 44).

SBI for alcohol has emerged as a cost-effective preventative approach which is relevant and practicable for delivery in primary care settings (Raistrick, Heather et al. 2006). Indeed there is a large body of research evidence acquired over the last three decades (Kaner, Beyer et al. 2007, O'Donnell, Wallace et al. 2014) to support the effectiveness of screening and brief intervention for alcohol in primary care. Brief interventions have two guises. One being simple structured advice; typically lasting 5-10 minutes, this intervention comprising of personalised feedback regarding how to avoid the adverse consequences of alcohol and/or how to address problematic drinking behaviour. Alternatively, extended brief interventions generally last 20-30 minutes and incorporate techniques such as motivational interviewing (NICE 2010).

It is suggested that if a brief intervention is undertaken with a hazardous or harmful drinker they were twice as likely to moderate their drinking within the 6 to 12 months following the intervention compared to individuals that do not receive an intervention (Department of Health 2005c). The potential to intervene and utilise GP consultations and primary care settings to both detect alcohol problems and deliver brief interventions has been identified (Lock 2009), with individuals using alcohol consulting their GPs nearly twice as often as the average patients (Royal college of Physicians 1991). A recent report published by Public Health England (2013) stated that 67 Accident and Emergency visits and 61 hospital admissions may be prevented for every 5,000 patients screened in primary care. Despite primary care being identified as an ideal setting to conduct screening and brief interventions, attitudinal data found that time pressures, lack of training and a supportive environment have all been identified as barriers to involvement in alcohol interventions (Lock 2002, Rapley, May et al. 2006, Lock 2009).

It is identified by Baggott (1990) that alcohol is consumed by around 90% of the population and for the majority of adults in the UK alcohol is accepted and consumed both in routines of daily life and at significant events such as weddings and birthdays etc.(University of Stirling 2012). The policies that have been published have mirrored the politically popular options with both the 2004 and 2007 strategies promoting alcohol education, media campaigns and social marketing all of which have resulted in limited impact on both the consumption of and harm related to alcohol (Alcohol Concern 2009). The inconsistency between evidence based interventions and policy initiatives has been a contentious issue and in a recent House of commons health committee report the government was criticised for being too close to the drinks industry. It was stated that “the drinks industry and supermarkets hold more power over UK government alcohol policies than do expert health professionals”(House of Commons Health Committee 2009). The mismatched spending can be seen in the fact that £17.6 million was spent by the government on alcohol awareness in 2009/2010, this was however far outweighed by the £600-£800 million spent promoting alcohol by the drinks industry(Alcohol Concern 2009).Historically, the main focus for alcohol has been on treatment and illness rather than on prevention within which interventions would occur prior to conditions becoming unmanageable.

Furthermore, despite the availability of information surrounding the rise in alcohol related harm, highlighting increased availability, affordability and promotion of alcohol as pivotal factors and a significantly better understanding of the impact of alcohol related harms; to date, policies in England fail to implement the repeatedly reported effective strategies of the introduction of minimum pricing, increased tax and restrictions on availability and advertising. The predominant focus on the requirement of heavy end treatment as opposed to the preventative agenda could have an implication for the type of stakeholder commissioners attempt to engage. There is a challenge with regards to the focus and balancing the intangible preventative agenda against the more obvious treatment need. This imbalance focus may result in an assumption that service user stakeholders are recipients of treatment not those requiring preventative input as it is hard to identify the preventative stakeholder group due to them being so close to mainstream population in many respects.

Chapter 3 : Literature Review

3.1 Chapter overview

This chapter provides a critique of the current literature on the impact of stakeholder involvement in alcohol commissioning decisions making reference to the related policy documents. An important element of the commissioning process is that it is inclusive of and transparent to stakeholders which in turn ensures services are responsive to the community's needs (Department of Health 2010a). Therefore, with this in mind the following sections explore what is meant by stakeholder involvement in health care. In particular the chapter explores the complexities of defining stakeholder involvement, stakeholder involvement in commissioning, models of stakeholder involvement and barriers to stakeholder involvement. Within the health care literature the terminology of public and patient involvement and stakeholder involvement is used to denote the same concept. In the following section the term stakeholder involvement is used to embrace both terms. Furthermore, the terms 'stakeholder involvement' and 'stakeholder engagement' are used interchangeably.

3.2 Stakeholder involvement in health care

3.2.1 Complexities of defining meaning of stakeholder involvement

The meaning of the term stakeholder involvement is somewhat ambiguous (Thompson 2002, Rutter 2004) and can hold different meanings for service providers, users and policy makers depending on the individual circumstance (Florin and Dixon 2004, Fudge 2008). A stakeholder can be described as "any group or individual who can affect or is affected by the achievement of the organisation's purpose and objectives"(Cornelissen 2008:42). Consequently, there is the potential for anybody to be a stakeholder, a stakeholder's identity is not static and levels of interest and influence may fluctuate over time and across the issues facing an organisation. Furthermore, stakeholder involvement can be defined in different ways depending on the environment. For example, 'consumerists' would define participation as, finding out what service users want and how services can be shaped to meet those needs; 'democrats' would, however, claim that participation equals empowerment (Lupton 1998, Kemp 2010). In addition, even when thinking

specifically of an individual accessing services, terms such as patient, client and customer are used interchangeably depending on the context. Although, these terms are generally adopted in different settings, for instance patient within a health care setting, client in the social care setting and customer when service users become purchasers of a service. This idea of multiple identities is relevant to the widespread nature of alcohol problems within which an individual could be all three things at once. This comes from the fact that an individual could be a patient within a GP surgery, a client in touch with probation or social services and may also be a customer accessing private residential care. However, the connotation of these terms is variable, with patient implying a degree of paternalism and customer that of an individual who receives services and has the ability to choose between suppliers, implying a greater degree of control and independence. There is also an implication within documents that alcohol service users are a homogenous group when in reality a unified group does not exist. Whilst the choice of terminology might be a matter of semantics, it highlights how confusion arises when trying to define who a service user is and equally establishing who stakeholders are regarding alcohol service provision. Furthermore, even when stakeholders have been identified, the definition of what constitutes stakeholder engagement is elusive. Types of engagement can vary significantly and involvement of stakeholders can range from a one off consultation or a paper based questionnaire seeking feedback on an aspect of care to continuous involvement in the design, delivery and management of services (Plunkett 2008). In the specific context of the research reported here, stakeholder involvement is used to indicate the participation or engagement on various levels by individuals who are involved in the design, planning, development and delivery of services.

3.2.2 The national policy context and benefits of stakeholder involvement

The notion of stakeholder involvement and providing individuals with a 'voice' has been an aim of official health care policy over the last couple of decades (Borg 2009). Development of stakeholder involvement may be seen as a response to two major factors: "Public demands for a greater voice in decisions about their services, and demands from politicians for greater efficiency, quality of service and effectiveness in the use of public funds"(Lewis and Hinton 2008, Gibson 2012

:531). The impetus behind the trend to incorporate the stakeholder's voice is multifaceted; stakeholder involvement has the ability to enhance the accountability of service providers towards the wider stakeholder community (Stoker 2006). The collection of multiple perspectives increases the likelihood of services being more adaptable to the local context (McMurray 2007) and if a large number of stakeholders contribute to the decision making process it increases the legitimacy of the decisions being made (Veronesi and Keasey 2009). There are a number of well documented benefits associated with stakeholder engagement. Stakeholder engagement has the potential to expose everyone involved to diverse and varied perspectives which enable a clearer picture to be obtained regarding the community context that exist. It reduces the likelihood of commissioners unexpectedly being presented with community concerns they were unaware of and it allows more ideas to be considered than if consultation was only aimed at a small group of likeminded people. Furthermore, it strengthens democracy and facilitates 'buy in' and support from stakeholders as they also become integral to the success or otherwise of services. Last but not least it increases the likelihood of success and sustainability of services if they endeavour to meet the needs of stakeholders affected by them (Jeffery 2009, Veronesi and Keasey 2009, Luoma-atio and Vos 2010).

An increasing number of policy documents have emerged over the last couple of decades to promote active participation of stakeholders at each stage of service provision and advocate for a greater responsiveness to users within the NHS. This stated commitment to the NHS becoming increasingly inclusive of the stakeholder voice has been continuous and the Health and Social Care Act 2012 is the most recent manifestation. The Act supports two legal duties which require Clinical Commissioning Groups to enable; "Patients and carers to participate in planning, managing and making decisions about their care and treatment" and "the effective participation of the public in the commissioning process itself" (NHS England 2013c: 6). The regular involvement of stakeholders enables individuals to develop an understanding of complex situations and the ability to envisage a community-wide solution as opposed to an individual solution (Redding 2014). This in turn will enhance the credibility of services by promoting an understanding of the issues, reducing uncertainty and promoting trust and legitimacy on behalf of service users (Abelson 2004). Stakeholder involvement is an important element of commissioning

practice as it helps to promote an increase in personalisation of care and requires commissioners to become more responsive to the needs of the communities they serve. As Jeffery states “organisations can no longer choose if they want to engage with stakeholders or not; the only decision they need to take is when and how successfully to engage”(Jeffery 2009 :8).

3.2.3 Stakeholder involvement in commissioning/decision making

Focusing specifically on stakeholder involvement in the commissioning process, it is important to consider the importance to place on stakeholder engagement within the commissioning context. Decision-making is pivotal to setting the commissioning agenda, in its simplest form decision making is the act of choosing between two or more courses of action. The world class commissioning framework was one of the most recent policies to charge NHS commissioners with the task of proactively seeking continuous and meaningful engagement with stakeholder and fully engaging local people in decision-making, being aware of their needs and addressing them in the most effective ways (Department of Health 2007c). A recent guide, ‘Transforming Participation in Health and Care’, published by NHS England states that NHS commissioning should;

- “Make arrangements for and promote individual participation in care and treatment through commissioning activity
- Make arrangements for the public to be engaged in governance arrangements by ensuring that the clinical commissioning groups governing body included at least two lay people
- Listen and act upon patient and carer feedback at all stages of the commissioning cycle- from needs assessment to contract management
- Publish evidence of what ‘patient and public voice’ activity has been conducted, its impact and the difference it has made
- Engage with patients, carers and the public when redesigning or reconfiguring healthcare services, demonstrating how this has informed decisions”

(NHS England 2013c: 4)

This guide alluded to the fact that the involvement of stakeholders within the commissioning process provides mutual benefits for all parties involved. Involvement

in commissioning has the potential for stakeholders to gain a better understanding of how the NHS operates, which in turn results in a more appropriate use of health services due to the shared responsibilities for health care being distributed between NHS services and stakeholders (NHS England 2013c). Additionally, it is widely recognised that patients experiences of health services are a valuable resource (Department of Health 2009b). Elliott and Williams (2008) have argued that the experiential wisdom that lay people hold is a form of legitimate expertise which can become 'the basis for a powerful form of knowledge production' adding an extra dimension within the commissioning process. Furthermore, it has been argued that if stakeholders become involved in commissioning and their knowledge is increased, they may become more sympathetic to the tough decisions that commissioners have to make (Irvine and Stansbury 2004).

When considering many policy documents and guidance advocating stakeholder involvement in the NHS, the terminology makes reference predominantly to patients and carers involvement in the NHS system. Within health, stakeholders such as voluntary and community organisations and social enterprises work closely with the beneficiary groups that they serve, in this case individuals who consume alcohol. These stakeholders have the potential to play a key role to be innovative and offer services that provide real value for money as they have the flexibility to be responsive to identified need. When commissioning services, resources need to be used with care and justification therefore, consultation with a broad range of stakeholders with a legitimate interest in reducing alcohol related harm is pivotal. Additionally, if stakeholder engagement is to be successful, it "needs to be inclusive, equitable and adequately resourced" (Cluzeau 2012: 270).

As referred to in Chapter 2, commissioning has recently moved to Clinical Commissioning Groups. Despite this reconfiguration occurring, the drive to improve patient involvement in their own care and in the planning of services has continued. It has been stated that "GP consortia will need to be proactive in seeking out the views and experiences of the public, patients and their carer's and other stakeholders, especially those least able to advocate for themselves" (NHS Institute for Innovation and Improvement 2011 :1). Engagement with stakeholders is described as an ongoing process in which constructive relationships are sustained

and meaningful dialogue is undertaken. There is a strong political imperative for the current commissioners of healthcare to demonstrate their ability to conduct meaningful engagement with stakeholders at all levels (Horrocks 2010). There are a number of studies that suggest a disparity exists between the levels of shared decision making reported by health professionals and the extent of shared decision-making occurring in practice in both care delivery and the commissioning process (Stevenson 2004, Coulter 2006, Da Silva 2012).

A literature review conducted by Chisholm et al (2007) found that the most prevalent use of stakeholder involvement in commissioning was at the point of service design with 84% of PCTs reporting engaging stakeholders for that reason. When considering commissioning decisions, Chisholm (2009) argued that empirical data states that public views actually influencing decisions is very thin. This may be partly due to the fact that participation by stakeholders is not constant, and the views held by the public are not necessarily perceived to be clear and/or consistent. In a study by Williams et al (2001) it was reported that the *intent* of members of the public to participate and the reality of them requesting more information to join participatory processes was significantly different.

For substance use services specifically, despite the National Treatment Agency strongly endorsing involvement of service user stakeholders, when in existence the Drug Action Teams were required to report on the development of stakeholder involvement in the annual treatment plans or include it within service development objectives (NTA 2013). In the absence of reportable indicators, commissioners allocate resources elsewhere to contribute towards more measurable targets. The findings of King's (2011) study suggest that service users (in drug treatment) remain "passive players in the planning, development, delivery and evaluation of treatment services" (King 2011: 276). The finding by King could also be extended to service users with primarily alcohol needs in cases where their problems are sufficient enough to require a medical detox or specialist therapeutic interventions. However, many potential stakeholders e.g. individuals receiving a single screening and brief intervention via a GP would not automatically be approached to become involved in consultations.

Additionally, only a limited number of service users seek to be involved in engagement events and the challenge of sustaining involvement is intensified due to instability of stakeholder opportunities (Patterson 2009). The guidance that is available to local authority commissioners of alcohol services, reports that drawing on the unique expertise and experiences of users may be central to achieving desired outcomes (NTA 2002). Despite guidance being available, Schulte et al (2007) comment that the level of stakeholder involvement is low within UK drug and alcohol treatment services with Bunce (2005) stating that it is apparent that there has been limited influence from users. It is less clear as to why levels of stakeholder engagement have remained low although ambiguity concerning what involvement actually is undoubtedly contributes to the lack of progress. Furthermore, issues of power imbalance, language barriers, and lack of motivation on behalf of stakeholders all hinder the engagement process, and are discussed later in this chapter.

3.2.4 Models of stakeholder involvement

Arnstein's (1969) model of citizen engagement depicts one interpretation of the various levels of stakeholder involvement that can exist, see figure 7. This model was initially published in 1969 with regard to citizen involvement in the planning process in the United States. Arnstein published this ladder whilst working as the Director of community development studies in America. In the decades since its publication, the ladder has been used within social sciences to highlight the participation and non-participation of citizens in democratic processes (Arnstein 1969). The ladder provides an overview of the potential ways in which people in a community can be involved in decision making.

Arnstein (1969) Ladder of citizen participation



Figure 7: Arnstein's ladder of citizen engagement

Arnstein argued that only the top three rungs of the ladder - partnership, delegated power and citizen control - represented genuine participation with people, with the five rungs below symbolising tokenism. Tokenism being “the practice of making only a perfunctory or symbolic effort to do a particular thing, especially by recruiting a small number of people from underrepresented groups in order to give the appearance of equality”(Oxford Dictionaries). The ladder highlights that “there is a critical difference between going through the empty ritual of participation and having the real power needed to affect the outcomes of the process”(Arnstein 1969). The rungs are discussed in further detail in figure 8 below:

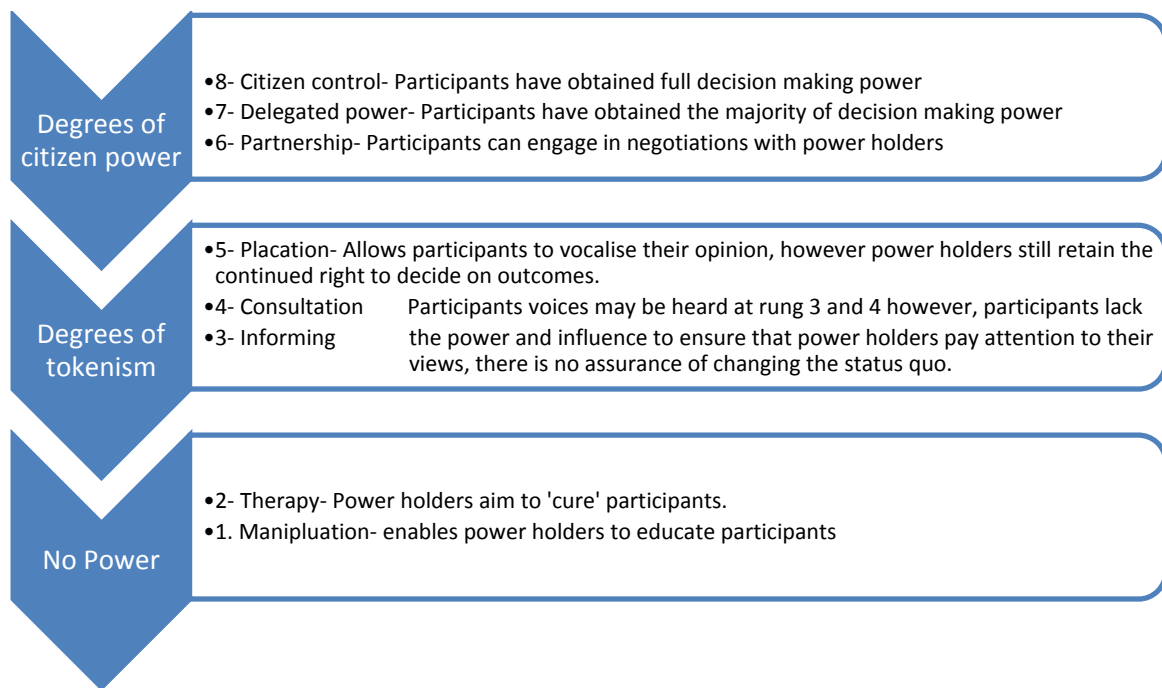


Figure 8: Rungs of citizen engagement

Commentators such as Feingold (1977) Burns et al (1994) and Wilcox (1999) have redesigned Arnstein's model to fit their respective contexts that they are working in. Each model expanded or collapsed the amount of rungs 'necessary' to fit their perception of the varying levels of participation. These commentators acknowledged that different levels of involvement are appropriate at different times to meet the expectations of different stakeholders involved in the process. The adapted models can be seen in table 5.

Feingold (1977)	Burns et al (1994)	Wilcox (1999)
<ul style="list-style-type: none"> •5. Citizen control •4. Delegated power •3. Partnership •2. Consultation •1. Informing 	<ul style="list-style-type: none"> •Citizen control •12. Independent control •11. Entrusted control •Citizen participation •10. Delegated power •9. Partnership •8. Limited decentralised decision making •7. Effective advisory boards •6. Genuine consultation •5. High quality informatio •Citizen non-participation •4. Customer care •3. Poor information •2. Cynical consultation •1. Civic hype 	<ul style="list-style-type: none"> •5. Supporting individual community initiatives •4. Acting together •3. Deciding together •2. Consultation •1. Information

Table 5: Adapted models of stakeholder involvement

All of the ladders of participation, regardless of the author, present a model of increasing involvement and opportunities to influence the outcomes on behalf of stakeholders and the hierarchical approach to participation put forward by Arnstein has been retained (Tritter and McCallum 2006). The ladder of participation proposed by Wilcox recognises that different levels of participation are inevitable in differing context and settings (Wilcox 1994, Wales centre for health 2009). The desire for different forms of participation to be given equal recognition depending on the context was reiterated by Martin and Boaz (2000) who stated that they had decided to lie the ladder down. Their perception was that all three forms of participation - communication, consultation and co-production - are all vital components when considering the involvement of stakeholders.

Arnstein's ladder highlights the complex nature of ensuring stakeholder involvement occurs at a variety of levels to enable stakeholders genuine opportunities to influence decisions within treatment services. In reality, this linear, hierarchical model fails to reflect the dynamic and evolving nature of stakeholder involvement. The varying levels of participation are likely to be increasingly more complex than the seemingly simple series of rungs outlined in the ladders of participation models above. A further criticism of the use of a ladder to signify levels of participation, apart from the models proposed by Wilcox and Martin and Boaz, is that it infers a

hierarchy of engagement and implies that the more control participants obtain, the better (Wales centre for health 2009). In spite of this perceived view, the uppermost rung of citizen control may not be the goal participants are striving for. Increased control is not always desirable especially related to health where a degree of paternalism may still exist. Furthermore, for many stakeholders (especially individuals with serious conditions) they may prefer to delegate power as there is still a belief that medical professionals know best and many stakeholders do not want the responsibility of making the wrong decisions. Additionally, within the health and social care environment information asymmetry often exists (Department of Health 2012e). When an asymmetry of information is present individuals may opt to defer to professional judgement not for paternalistic reasons but for more practical and technical reasons. Even the most 'medically aware' patient may feel lost when deciding which treatment option to select and they may request support from health care professionals (Epstein R and Street R 2011). Within healthcare, differences in the levels of information held are often present and the understanding on behalf of patients accessing care as opposed to those who work in or with the system will often be unbalanced resulting in service provider often having superior knowledge (WHO 2004).

Furthermore, an unavoidable conflict arises when reaching the citizen control level of participation. Inevitably commissioners and/or the expert professional organising the stakeholder involvement events will be being paid to assume the decision-making responsibilities (Rowe and Shepherd 2002). The likelihood of surrendering that responsibility completely is limited, resulting in the level of citizen control rarely being reached. Although, citizen control may not be the ultimate aim equally, levels of participation that denote tokenism are also undesirable to all parties involved, especially members of the public and patients. As suggested by Allott and Holmes (1993) at the level of tokenism there is limited opportunity for consultations and the failure of genuine participation results in stakeholders becoming increasingly disenchanted and disinterested in engaging with the process (Skelcher 1993, Wilcox 1994, Hart 1997). In spite of this, Allott and Holmes continue to state that from a positive perspective, "tokenism means that at least the concept of service user involvement has been recognised" (1993: 573). At the highest level, stakeholder involvement has been defined by Hickey and Kipping as encompassing an equal

relationship between service users and providers in which decisions are made jointly (1998), suggesting that 'partnership' is the most desirable level to aim for. The notion of co-production becomes relevant at this point as there is a significant difference between co-production and participation. Whilst participation means being consulted, the inference of co-production is that of being equal partners and co-creators (Social Care Institute for Excellence 2013).

Having opportunities for stakeholder involvement to occur is the key factor to be considered but the precise form or level of engagement needs to be considered flexibly based on a range of factors including the service user's preferred level of engagement and involvement.

3.2.5 Barriers to stakeholder involvement

3.2.5.1 Power to influence

It is well recognised that the hierarchy of power that exists within organisations often leads to a tension between various individuals and/or groups. Commissioning decisions can be described as "ultimately political in that they involve decisions with uncertain outcomes, actors with conflicting views, and resolution through the exercise of power"(Eisenhardt and Bougeois 1988:737). When considering stakeholder involvement in commissioning decisions, commissioners have to be able to identify who their stakeholders are whilst also being aware of the levels of power, influence and interest each stakeholder holds. Despite the policy impetus of collaborative working, stakeholders may be prioritised depending on their interest and influence in the subject area. As Table 6 highlights, stakeholders fall into one of four categories labelled as; satisfy, manage, monitor or inform. As the table identifies there is the potential for a hierarchy of prioritisation to be present dependent on factors such as available time and resources. Some stakeholders will have the power to advance decisions and keep them on the agenda or block efforts if adequate consultation does not occur. The high power/high interest stakeholders are prioritised whilst the low power/low interest stakeholders may be ignored if time and resources run out.

High power	Satisfy Opinion formers. Keep them satisfied with what is happening and review your analysis of their position regularly.	Manage Key stakeholders who should be fully engaged through full communication and consultation.
Low power	Monitor This group may be ignored if time and resources are stretched.	Inform Patients often fall into this category. It may be helpful to take steps to increase their influence by organising them into groups or taking active consultative work.
	Low interest/stake holding	High interest/stake holding

Table 6: Power/interest grid for stakeholder prioritisation

(NHS Institute for Innovation and Improvement 2008)

Establishing who holds the most power and influence is not always easily identifiable and power can manifest itself in a variety of forms in relation to decision-making, French and Raven identified five forms of power that can occur. The types of power are defined as: coercive power within which a commissioner can force someone to do something against their will; reward power where a commissioner has the ability to give other people what they want; legitimate power is invested in a role that confers authority for example a police officer; referent power which occurs when another person likes you or strives to be like you; and finally expert power in which a commissioner has the knowledge and skill that someone else requires (French and Raven 1960). The location of power transfers in different circumstances according to who is perceived to be in a position of power in any given situation. Power can be situated within an individual, a team or an organisation and has the capacity to influence others (Pfeffer 1997). The structure and bureaucracy in any given environment has the potential to produce powerlessness in subordinates as the superiors dominate the decision process. Understandably stakeholders such as commissioners justifiably hold more power to influence decisions than service users due to their possession and control of resources, which enables them to dominate the decision-making process. Despite the impetus focusing on collaborative decision-making, in reality “power accrues to those who control resources needed by the organisation, creating power differentials among parties and it confirms that the possession of resource power makes a stakeholder important to managers”(Mitchell,

Agel et al. 1997: 12).The majority of service users and lay community members are not politically or economically powerful, but they may well possess a wealth of knowledge and experiences.

A distinct knowledge imbalance is present between professionals and service users regarding policies, procedures and treatment options. Due to the technical expertise possessed by professionals, it enables an authoritative role to be adopted as opposed to embracing an equal relationship based on professional expertise and personal knowledge and experience (Charles and DeMaio 1993). The technical knowledge that 'professionals' have acquired is frequently held with higher regard than the practical knowledge that a lay stakeholder may possess and contributions made on behalf of stakeholders may be unconsciously downgraded due to this (Gibson 2012).Power inequalities still exist amongst stakeholders and this may result in service users continuing to feel disempowered due to engagement attempts failing to acknowledge their experiential knowledge and undermining their expertise (Lindow 1991). An assumption is still present that expert knowledge has superiority over personal experience (Crawford 2003, Burnes 2009). It was suggested by Felton and Stickley(2004) that some professionals are unlikely to wish to give up their claim to expertise and control to 'subordinate' groups such as service users and member of the public. As stated by Morone(1990: 253) "the call for lay participation [has not only been one of] empowering an oppressed group but subordinating a dominant one". Despite stakeholder involvement being high on the policy agenda, evidence suggests that many clinicians are reluctant to involve patients in shared decision making (Coulter and Collins 2011, Coulter 2012, Stiggelbout 2012).Service users are often deprived of any real chance to contribute to decisions about their treatment and remain a relatively powerless and devalued group (Perkins 2001). It is important to recognise that if these challenges exist at the point of care delivery they are likely to be amplified at a commissioning level. Further clarity is still needed surrounding what needs to be done to achieve greater equality between professionals and patients/members of the community(Health Committee 2007).

The 'traditional' hierarchical system of power is challenged at times within commissioning. Lipsky(1980) introduced the idea of 'street-level bureaucrats', who

are front line workers for example police officers, health workers and doctors (all of whom are valuable stakeholders in the commissioning process). These street-level bureaucrats face a continual duality between ensuring policies and decisions are implemented and meeting their clients' needs. Street-level bureaucrats have a clear understanding of their clients and an intimate knowledge of resources and therefore occupy a unique position to hinder or bolster the implementation process. It has been acknowledged that street-level bureaucrats "have been observed to cope with chronically limited resources and unlimited client demands by rationing service, discriminating in the provision of services to more cooperative clients and rationalizing program objectives"(Peters and Pierre 2007: 308). Within alcohol commissioning, the 'buy in' from street level bureaucrats such as general practitioners, clinicians, emergency care staff and criminal justice agencies is highly important to successfully address alcohol related problems. Bearing this in mind it is therefore important that commissioning and the decision-making process ensures that stakeholders are effectively involved in decision-making and that power is distributed as evenly as possible across the stakeholder spectrum.

3.2.5.2 Communication and language

Stakeholder involvement has been reported to increase the relevance and legitimacy of healthcare services(Flinterman 2005). For stakeholder engagement to occur communication has to be initiated and this in itself can be problematic. The importance of effecting clear messages is pivotal, as communication is the process used to successfully coordinate an organisation and its subsystems. Communication allows information and knowledge to be obtained, transferred and stored by individuals and within organisations (Rohman 1972). When liaising with stakeholders, Van Wersch and Eccles suggest that the perspectives of lay members may lack objectivity and may be invalid. This is due to the difficulties that can occur for service users in understanding the language and technical jargon within discussions and not attributing significant importance to the scientific evidence available (2001). Foucault (1972) also acknowledges the important concept of 'professional language' and states that the jargon used by individuals at the top of the institutional hierarchy excludes those who have not been exposed to their language. By default participants unfamiliar with the necessary vocabulary will be unable to influence discussions and therefore remain powerless. Ironically, if service

users become articulate enough to advocate for themselves, they tend to lose their status of being 'representative' of the user group. Rose et al accentuate the dilemma this creates by stating "ordinary users are not articulate. Activists cannot speak on behalf of ordinary users and ordinary users cannot speak for themselves. In such a discourse, no service user can have a voice"(Rose 2010: 390).Despite the need for good communication, problems occur within organisations or across partnerships due to confusion or incongruence because of inaccessible language, contradictory actions and cultural differences for example. As the complexity of an environment or system increases, so does the potential for confusion regarding the desired outcome, as potentially each stakeholder has (or may have) a different agenda. Further complicating the issue of communication and decision making is the diverse spectrum of stakeholders involved in alcohol commissioning and the wide reaching consequences of alcohol misuse.

Regarding the communication process there are two broad theoretical categories of communication: the programmatic and participatory approaches. Whilst the programmatic approach to communication emphasises a top down, 'one way' dissemination of information, the participatory approach in contrast accentuates the solicitation of ideas and input from a multitude of stakeholders (Russ 2008). The participatory model recognised that communication is (or should best be) reciprocal and it focuses on exchanges occurring between the sender and receiver. Throughout the communication process "senders and receivers are simultaneously sending and receiving messages"(Harris 2002:17)this model, therefore begins to explain the dynamic nature of human communication (Rimal and Lapinski 2009). In addition, throughout the communication process individuals shape and create their own social reality. Meanings are formulated through negotiating consensual interpretations of activities and interactions.

Additionally, within the transaction procedure certain characteristics have to be recognised such as;

- "the process is complex and dynamic- transactions are contextual and therefore irreversible, unique and unrepeatable;

- As a process communication has no beginning or end- almost all organisational communication occurs in the context of ongoing activities, relationships and goals;
- Everyone can be simultaneously affected and can affect every other member of the transaction”

(Harris 2002:18)

3.2.5.3 *Obtaining a balanced representation*

When attempting to conduct stakeholder involvement, commitment and motivation on behalf of the individual stakeholders to participate can create barriers. It is commonly suggested that patients and members of the public appear reluctant collaborators in health care practice (Waterworth and Luker 1990, Crawford 2003). Numerous contributory factors are recognised on behalf of stakeholders such as patients and members of the public when considering the lack of engagement and go towards creating a self-fulfilling prophecy of stakeholders not getting involved when opportunities arise. Tokenistic involvement where service users feel that their time has been wasted or their views have seemingly gone unheard, have been undervalued and/or a lack of communication surrounding their involvement all serve to widen the power gap between professionals and service users and can result in a lack of engagement and sense of disempowerment (Flinterman 2005, Auckland 2010).

Furthermore, literature acknowledged that it can be problematic to achieve the appropriate cross section of stakeholders to represent the demographics of the population (especially in the case of alcohol as this could be anyone) and a biased or singular view may be obtained. In instances where the ‘lay professional’ or only the ‘usual suspects’ participate, issues of generalizability become paramount. There is the potential for engagement events to be dominated by individuals with a vested interest. A balanced representation would be needed to provide the appropriate insight rather than focusing on one particular sub set of the population. The concept portrayed by Mays and Pope as ‘fair dealing’ was important when considering stakeholders. It is described as ensuring that stakeholder involvement “explicitly incorporates a wide range of different perspectives so that the viewpoint of one group is never presented as if it represents the sole truth of any situation”(Mays

2000: 51). An important aspect of stakeholder involvement is to capture the multiple perspectives held regarding the same issue and highlight how concepts can hold different meanings for each individual.

This is further complicated as the needs of an individual and the surrounding population are not static and may vary significantly. Therefore, engagement needs to be proactive, constant and meaningful. Variable factors influencing a stakeholder's ability to engage can include their mental health status, the condition of their physical health and any caring responsibilities they may have, to name a few. Any of these issues may render engagement problematic for individuals. Furthermore, commissioners have the daunting task of balancing the needs and wants of individuals within the economic restrictions and political boundaries set out in the policy documents. Commissioners have a responsibility to address tensions that may arise when considering the varying values, needs and interests of individuals and the society at large further intensifying the problems/issues of ensuring effective stakeholder involvement.

3.3 Barriers for professionals- Engagement failure

On behalf of professionals, the actual undertaking of stakeholder involvement can have number of barriers associated with them. Fundamentally, if an organisation does not have the appropriate expertise to engage stakeholders beyond the 'easy to reach' population it has the potential to devalue the process (Crawford 2003). On the other hand, the more diverse the group of stakeholders, there is an increased likelihood that what constitutes as a positive outcome may differ between stakeholders creating a further dynamic that has to be effectively facilitated. It has been suggested by Griffiths et al(2007) that positive stakeholder engagement is not always guaranteed as for some stakeholders they may have a vested interest in maintaining the status quo. Furthermore, stakeholder involvement can be expensive and time-consuming to organise and facilitate, in turn running the risk of slowing down the development and/or the implementation of new services. Consequently, engagement failure occurs due to many reasons including a lack of trust, competing priorities of stakeholder groups, a lack of perceived interest and/or difference in values (Jeffery 2009).

In a health setting there are continuous pressures to meet performance targets which diverts both resources and energy from engaging in lengthy consultations with stakeholders (Patterson 2009). In addition to having limited time allocated to stakeholder engagement events; factors such as human fallibility and cognitive limitations on behalf of the decision makers are also influential within the commissioning context (Braybrooke and Lindblom 1963, Eisenhardt and Zbaracki 1992). However, whilst these barriers may be logical reasons as to why stakeholder involvement is not undertaken, failure on behalf of professionals to integrate the voices of patients and the public, has the potential to undermine the legitimacy of the decisions being made and could ultimately lead to policy failure (Hoggart 2004).

3.4 Chapter Summary

Despite increased attention regarding stakeholder involvement in recent decades it has been identified by a number of commentators (Rose 2003, Hansen 2004, McCabe 2004, Beresford 2005) that within many clinical settings stakeholder engagement remains rhetorical. Although examples of genuine involvement exist, non-expert and user involvement are not accepted universally and Irvine (2000) suggests that few professional groups have created an environment that enables stakeholders to be on truly equal terms with them. The commitment of policy-makers to stakeholder involvement has been questioned due to the limited progress made to move towards co-production rather than tokenistic consultation (Rudman 1996, Pilgram and Waldron 1998). Ridley and Jones suggest weaknesses occur surrounding stakeholder involvement because “there is a general lack of focus and confusion about what it is; and second that many innovations have been one-off projects or events and involvement is not perceived as integral to the way the service looks” (2002: 33)

The literature indicates that the reality of stakeholder involvement does not fully live up to the ideal (McCrae 2002). It is therefore possible to conclude that tensions between rhetoric and reality exist at multiple levels from an individual service user level, where individuals demand inclusion but decline to engage in involvement events, to politics in which policies consistently identify the importance of stakeholder involvement but fail to provide guidance or formalise good practice to ensure that it actually occurs. Regardless of the reasons for the seemingly unavoidable

dissonance between idealism and reality, the outcome is that alcohol stakeholder's do not currently influence decision-making as fully as policy proposes that they should. One factor that may contribute to the lack of progression regarding stakeholder involvement is the continuous change affecting services, and the disruption this brings, and lack of time to embed policy objectives.

Chapter 4 : Methods and Methodology

4.1 Chapter overview

This chapter sets out the theoretical perspective adopted in this research and the methodology chosen to meet the research objectives. The use of qualitative research and the methods of data collection and analysis are described and justified at each stage. This chapter takes a pragmatic approach to illustrate the appropriateness of the research methods chosen.

4.2 Qualitative approach

This research was concerned with obtaining the views and beliefs of stakeholders to ascertain their perceived influence regarding the organisation, design and delivery of frontline alcohol services. It aimed to gain an understanding of the commissioning process and the influential factors that affect the commissioning decisions that are made. A qualitative approach was selected in order to enable this attention to depth of understanding to be sought. Such an approach enabled the research to focus on “how the social world is interpreted, understood, and experienced; involves methods of data collection that are flexible and sensitive to the social context; and utilises methods of data analysis, explanation and argument building that require developing an understanding of the complexity, detail and context of the data”(Bate 2008: 73)

When determining which approach to take to complement the research question, Guba and Lincoln (1994) suggest considering the responses given to four questions relating to ontology, epistemology, methodology and methods. The approaches adopted within this thesis are described in further detail below. The four stages of the research strategy are shown in figure 9.



Figure 9: The 4 stages of a research strategy

4.3 Ontology: Interpretivism

Ontology refers to the nature of reality and what may be known about it. A spectrum of ontology exists according to Morgan and Smircich(1980) ranging from an objective stance (positivist) in which reality is viewed to be concrete, to a subjectivist stance(interpretivist) where reality is seen as a projection of the human imagination. Healy and Perry (2000) further explain that positivism concerns a single concrete reality, interpretivism concerns multiple realities. People's perceptions of the world evolve as they encounter different environments and apply their own pre-existing understanding of reality. Depending on an individual's previous experiences, knowledge and current situation, the same object will have very different meaning for different individuals (Bond and Bond 1994). Therefore, the concept of truth becomes elusive as meanings "do not merely reflect the world as it exists, but are produced or constructed by persons and within cultural, social and historical relationships"(Henwood and Pidgeon 1994:109). Multiple realities and truths exist in response to an individual's interpretation of events which simultaneously enable us to understand and construct the social world around us (Grant and Giddings 2002).

When describing qualitative data Morse and Richards (2002) propose that data are made rather than collected; they suggest that "to speak of data as being 'gathered' is to imply that data pre-exists, ready to be picked like apples from a tree"(Morse and Richards 2002:87). This quote highlights the importance of generating data, accepting that things that hold true for an individual today may not hold true in the future or in an alternative social context. From the interpretivist perspective, the collaborative relationship between the researcher and the participants is emphasised as central to the co-construction of data (Grant and Giddings 2002). An interpretivist approach was adopted in this research and in line with this approach; the data collected are presented as a representation, report or an account of an event. In this study, this involved exploring the participants stories, ideas and knowledge of commissioning and their involvement in the decision making process. The key features of the interpretivist approach are identified in Figure 10.

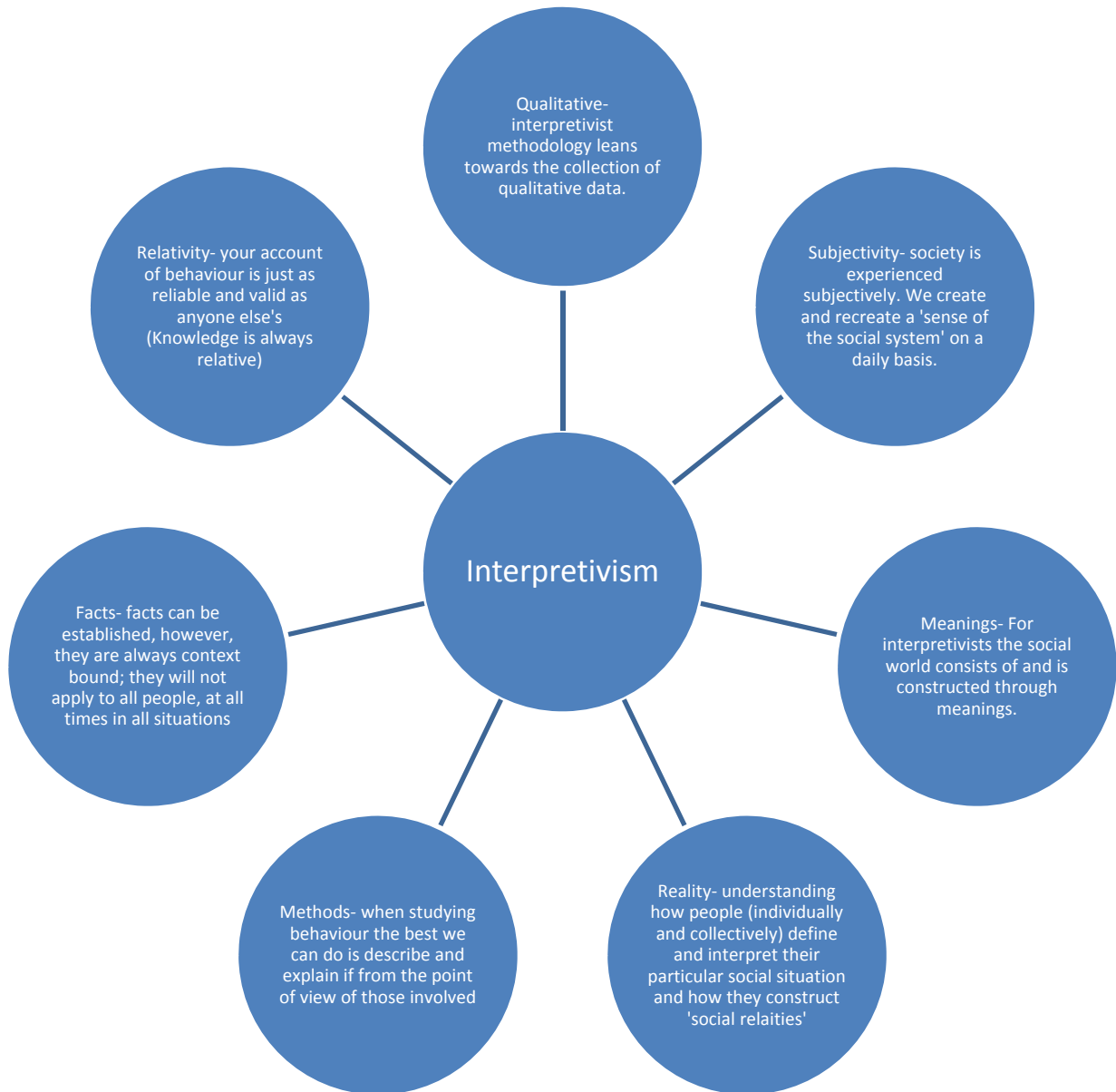


Figure 10: The Interpretivist Approach

Interpretivism recognises the significance of exploring an individual’s interpretation of events and accepts that the social world is produced and reproduced on a daily basis. This research set out to explore the many truths held by individuals by exploring the meaning people attached to events in their lives. The areas of exploration regarding stakeholder involvement in commissioning included: identifying who stakeholders were perceived to be, investigating the perceptions of stakeholders with respect to the extent of their involvement in commissioning

decisions and exploring the impact of stakeholder involvement on the organisation, design and delivery of alcohol services.

4.4 Epistemology: Social Constructionism

Epistemology is the investigation into the grounds of knowledge itself, it focuses on an individual's means for acquiring knowledge and how that individual differentiates between truth and falsehood. The epistemological perspective taken in this research is Social Constructionism. Social constructionism asserts that it is social and interpersonal interactions that shape an individual's reality. Individuals are influenced by others around them with whom they interact. Social constructionism focuses on the contextual details and when considering the interpretations of data, the social context within which the data collection occurred has to be taken into account.

According to Arksey and Knight (1999) all accounts of reality are 'visions of reality', what is important is that the researcher deals with the 'reality' as "people imagine it to be"(1999: 14). In this piece of research reality is viewed from the differing perspectives of the research participants' and gives primacy to their understanding of their involvement in and influence over alcohol commissioning decisions; which are in turn influenced by their experiences of the world. It is acknowledged that participants are experts in their own lives and the role of the researcher was to explore the socially constructed meanings of their reality. Central to a social constructionist perspective is the use of language and social interaction to construct meanings.

4.5 Sampling

Sampling is the process of selecting people, settings or phenomena to study(Mason 2002). Patton(2002: 273)suggests that the function of purposeful sampling is to "select information rich cases whose views will illuminate the question under study". Within the thesis, various types of purposive sampling were used including maximum variation (participants chosen to be as different as possible from one another), typical case (participants chosen who 'fit the norm' of a given population) and snowball sampling (existing participants recruit future participants from among their colleagues or acquaintances) (Patton 1990). The rationale behind using these forms of sampling was that in contrast with quantitative approaches the sample chosen

was not selected on the premise of being a statistically representative sample of the population but aimed to include maximum variation of participants (Kaner, Beyer et al. 2007). The research sought to obtain views from recipients of care within primary, secondary and tertiary care, statutory and voluntary/third sector organisations whilst also being inclusive of service commissioners and GPs across multiple geographical locations.

Sampling continued until data saturation had been reached, the sample size was not predetermined at the outset; data collection occurred in a cyclical process: collection, analysis, collection, with recruitment of new participants ceasing when “a thorough understanding of the phenomenon under study has been reached”(Kuper 2008: 687). In practice this meant sampling until no new themes emerged in a particular category.

4.6 Methodology

4.6.1 A case study approach

A case study research design was utilised within this research. A case is “a phenomenon of some sort occurring within a bounded context. It can be an individual, a role, a small group, an organisation, a community, a nation, a policy, a process, an incident or event of some sort” (Punch 1998:152). Within this research the case being explored is the commissioning process and the case study, is alcohol, more specifically the health and social care service response to the problems caused by heavy drinking.

A case study was favoured as the research design as it allowed an in-depth understanding to be sought in a natural setting whilst also capturing the intricate and contextual detail of the environment. A common criticism of the case study approach is the lack of generalizability and a poor representation of the wider population. However, whilst acknowledging this criticism, it is argued that the aim of this thesis was to capture the complexity of a situation and generalisation was not the aim of the research (Yin 2009). It is stated by Gomm, Hammersley and Foster (2000:3) that the aim of a case study is to “capture cases in their uniqueness, rather than to use them as a basis for wider generalisation”. This holds true for this research as the issue of alcohol commissioning is multifaceted due to the cross-cutting nature of

alcohol misuse, the multiple stakeholders involved in commissioning decisions and the extent of the current alcohol problem. Consequently, although the findings are not widely generalizable, the findings from this study could be generalizable in the immediate area and some of the insights emerging from within the data may be relevant more generally to broadly similar situations even if the precise context differs.

The case study design has the capacity to incorporate several sources of data, such as interviews, focus group, observation and archived data, offering “an attractive way of using a variety of research methods to produce a rounded portrayal of an identified subject” (Davies 2007:34). Importantly the holistic and meaningful characteristics of the real life event can be retained. As proposed by Yin(2009) case studies aim to capture both a phenomenon (the real life event) and its context (the natural setting). A case study approach was advantageous in this research as it enabled the perspectives of various ‘actors’, inclusive of alcohol commissioners, alcohol service providers, alcohol service users and GPs as potential gatekeepers to medical treatment and a referral source into services to be sought. Specifically in this research, the case study provided the opportunity to consider how the inter-relationships and social processes occur within the environmental context and how they influence the commissioning decisions being made (Cassell and Symon 1994). Additionally the choice of a case study approach allowed multiperspectival analysis to occur (Hamel 1993) and capture the sometimes contradictory views that emerged both within and across participant groups (Stake 1995).

The case study was conducted over three phases of research which were undertaken over a 4 year period, beginning in February 2010 and concluding in July 2014. Figure 3 introduced previously in section 1.8, reiterates the different phases of

the case study and the sources of data and collection methods.

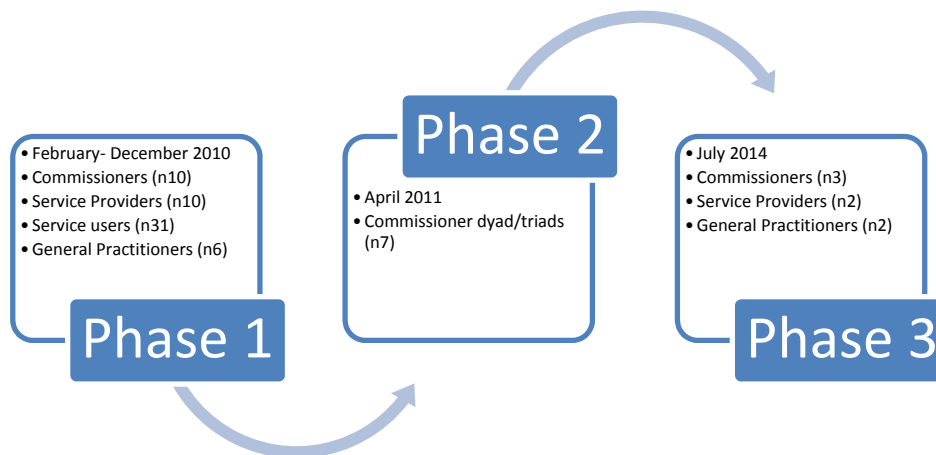


Figure 3: Phases of data collection

4.6.2 Interviews

Interviews were conducted to explore stakeholder involvement in commissioning. Semi-structured interviews were used to obtain data in this dynamic and fluid subject area. The flexibility of the interview approach and the scope for exploring unforeseen topics of discussion with participants was central to this decision. Mason (2002) identifies interviews as an opportunity to have a 'conversation with a purpose', Kvale and Brinkmann(2009:2) take the explanation a step further and state that "an interview is literally an inter-view, an inter-change of views between two persons conversing about a theme of mutual interest".

It is argued by Sommer and Sommer (1997) and Darlington and Scott (2002) that interviews encapsulate rich details that are based on privileged insights and insider experience and afford the opportunity to recognise individuals as experts in their own experience. Within this research, interviews aimed to learn about social life through the "perspective, experience and language of those living it"(Boeije 2010:61). By choosing to undertake semi-structured interviews, it allowed participants to divulge information that may be sensitive in nature.

An individual interview provided an insight into the current environment without participants being influenced by any hierarchical power issues that may be present within a group situation. The semi structured interviews allowed flexibility and adaptation to the interviewee and their context. Furthermore, the choice to conduct interviews on a one to one basis allowed the option of conducting a telephone

interview if a participant felt that they could only offer limited time or alternatively interviews could take place outside of normal working hours, a facility that would be much harder to coordinate with multiple participants.

In addition to individual interviews, a decision was made to undertake dyad/triad interviews for the second commissioner interviews, phase 2 of data collection. Strengths of using dyad/triad interviews at this point in data collection are that “dyadic interviews allow participants to stimulate ideas that might not have been either recognised or remembered” (Morgan 2013: 1277). The ongoing exchanges occurring within the interviews allowed participants to extend what the other has said. Furthermore, similarities and differences in the perspectives held by participants regarding the research topic could be explored. Dyad/triad interviews were chosen as they have the dual purpose of conducting an authenticity check for the findings that had emerged so far and also to capture any changes that had occurred in relation to alcohol commissioning since the initial interview 13 months prior. The findings from the dyad/triad interviews contributed to revising, refining and supporting the emerging analytic framework. Therefore, dyad/triad interviews in each locality were used to gather reflections from each team, rather than an individual commissioner’s perspective.

4.6.3 Focus Groups

A focus group “is often distinguished from other group interviews by its emphasis on a specific theme or topic that is explored in depth” (Bates 2008:92). Originating in marketing Kitzinger (1996), identifies that focus groups are a method of interviewing that involves more than one interviewee, typically 6-8 members, therefore in essence a group interview (Davies 2007). However, unlike a group interview, focus groups explicitly use group interaction to stimulate discussion and generate research data (Kruger 1994, Morgan 1998). The group interaction encourages participants to raise issues that are important to them, and as recognized by Kruger (1998) it permits them to raise their own questions and interrogate the views of others or revise and modify their own views.

Focus groups were used within the research to enable service users to verbalise their experiences of being involved in commissioning and their perceptions of their

influence on the design of frontline alcohol services. Focus groups were deemed advantageous compared to interviews for a number of reasons including the fact that, as identified by Darlington and Scott (2002), they enabled the exploration of a range of responses to a specific topic in a relatively short space of time.

Furthermore, the cross flow of communication sparked ideas for other participants and the pressure was reduced for participants to have to respond to every question. A group environment can provide participants with 'reassurance' and safety in numbers, whilst also having the advantage of the group dynamics stimulating discussion (Bowling 2002). Group interviews enabled data to be sought without placing undue pressure onto individual participants. In addition, groups could lessen the power differential between the researchers and researched but there can be shortcomings with regards to power and dominant voices within the group, as identified below.

Focus groups have the ability to produce rich data leading beyond that produced by a single interviewee it is claimed by Kingry et al (1990:125) that "the synergy of the group has the potential to uncover important constructs which may be lost with individually generated data". Furthermore, Barbour (2007:26) suggests that focus groups allow "collective sense to be made, meanings negotiated and identities elaborated through the process of social interaction with people". This was true of the service user focus groups as participants regularly reached a 'consensus' after partaking in a discussion surrounding a topic of interest. The reactions of group members to opinions and experiences expressed within the group was probed by the moderator (Basch 1987). Focus groups constituted an excellent way to explore issues and quickly established a wide range of experiences, views and knowledge (Lederman 1990).

However, alongside the positives, as with any approach there are potential disadvantages, one potential problem being the power dynamics within the group. Although this did not appear to be an issue within the focus groups or commissioning dyad/triads (all participants contributed, healthy discussions took place and it did not appear that anyone's voice was muted) there was potential for it to be problematic. When various different individuals are present it can influence interaction between group members (Bloor 2001). This was possible within commissioning dyad/triads

and focus groups due to potentially dominant individuals or participants with status or power being present within the group. Although it was not observed, (Sommer and Sommer 1997, Vicsek 2010) recognised that the problem of social pressure could influence the discussions taking place, resulting in an inaccurate portrayal of events as group members conform to the majority view. As a precautionary measure, within this research all participants were offered an opportunity to contact the researcher following their participation to discuss any further issues or areas of interest which had not been discussed within the group.

Issues of representativeness also create scepticism - the acknowledgement that “in a different group, or in the same group on a second occasion, they might have said something different” (Gomm 2004: 170). This was apparent within the service user focus groups as despite each group having the same topic guides and facilitator, the interpretation of questions and the focus of discussions varied significantly across the different sites. However, this is not viewed as a disadvantage within this research as it merely reinforces the multiple realities held by individuals and enabled the researcher to gain an insight into how participants construct the social world around them. A further issue of relevance to the conduct of the focus group was regarding the level of control the researcher had over the course of the interview. The level of control was potentially reduced due to the multiple personalities within the focus group and the limited amount of time to dedicate to each participant (Bloor 2001). Despite the focus groups having some potentially dominant participants present, in reality, this was the appealing quality of the focus group; to explore a group dynamic on a given issue. The criticism of interviewer control could be levelled to *all* research, as all research can be time and space bound.

4.7 Methods of data collection

4.7.1 Interviews

Deductive reasoning was used within this research and within each of the interview phases a thematic approach to collecting data was taken. As identified by Kvale and Brinkmann (2009) the semi-structured nature of the interviews allowed the interviewee to disclose a wealth of information whilst also providing flexibility for various avenues to be explored without being restricted by the constraints of a structured interview or questionnaire. Prior to the interviews taking place (both

individual and dyad/triad interviews), each participant was approached via telephone on an informal basis. Once participants had provided verbal consent to take part in the research, an appropriate time, date and location were agreed to conduct the interview. Participants were provided with an option of the interviews taking place on either a face to face basis or via the telephone at a time, date and location of their choice. All interviews took place at the participant's place of work. A participant information sheet (appendix 1 and 2) was provided via email to each participant a week prior to the interview, which included contact details should they wish to discuss any element of the research procedure. On the day of the interview, participants were asked to re-read the information sheet and sign a consent form (appendix 3 and 4) which gave their permission to audio tape and transcribe their interview.

A topic guide (appendix 5, 6, 7, 9, 10), covering general areas of interest was used within the interviews. This guide mapped out in detail some of the areas important to the project, whilst still allowing flexibility and scope for probing key issues and for exploring unexpected and emergent issues (raised by either the interviewee or interviewer) and also allowing opportunities to change the sequence to capture the stories of importance to the participant (Kvale and Brinkmann 2009, O'Leary 2010). The topic guides were not static and evolved throughout the interview process to reflect unanticipated areas of interest to the participants. In this research the guides were used to prompt the researcher and to ensure all participants' views were sought on a carefully selected list of topics without restricting them to answering set questions. The participants were encouraged to talk freely about their experiences and opinions in relation to the commissioning of alcohol treatment, reassurance was provided regarding data remaining anonymous. Interviews were not structured in a particular order and topics were ticked off as mentioned within the course of a normal discussion. Therefore, the order that the questions were asked were not verbatim and they varied in the order they emerged.

If confusion occurred within the interview, immediate clarification was sought from participants, enabling understanding of the meanings individuals attributed to their day to day experiences and activities to be explored. Inconsistencies within the

interviews were questioned in an attempt to produce data that created a more accurate reflection of each participant's 'truth'.

4.7.1.1 Commissioning interviews (phase 1: February- March 2010)

The first phase of data collection was with the alcohol commissioning team. Potential interviewees in this group were already aware of the research taking place due to NHS X funding the study. Participants were recruited purposefully, specific characteristics being that interviewees were all located within the alcohol commissioning team within NHS X. An alcohol commissioning officer within the commissioning team volunteered to act as a gatekeeper and a list of contact details for the entire alcohol commissioning team (n=21), was made available providing details of their location and job title. Members of the commissioning team were selected due to their roles as 'key members' of staff. Potential participants are shown in figure 11 and the actual participants that took part in an interview are highlighted in red. Initially, the Director of Public Health (DPH) in each locality was contacted, but in all three instances the researcher was redirected to the Head of substance misuse, commissioning and reform. The redirection occurred as the DPHs stated that the head of substance misuse would have the 'specialist' knowledge surrounding alcohol commissioning necessary for this study. A further eight key members of staff within the alcohol commissioning team were approached to take part in the research. They were chosen because they were all directly involved in the commissioning of alcohol interventions and within their various roles they could provide different perspectives regarding the commissioning process. Snowball sampling occurred within the commissioning cohort; whilst undertaking the 'key' interviews, a further three participants were identified by commissioners as having an alternative perspective regarding their involvement in the commissioning process. In response to the recommendations, two service user involvement officers and a senior data analyst were contacted and interviewed. In entirety, phase 1 (n=11) included; two heads of substance misuse, a senior data analyst, three joint commissioning managers, three alcohol commissioning officers and two service user involvement officers.

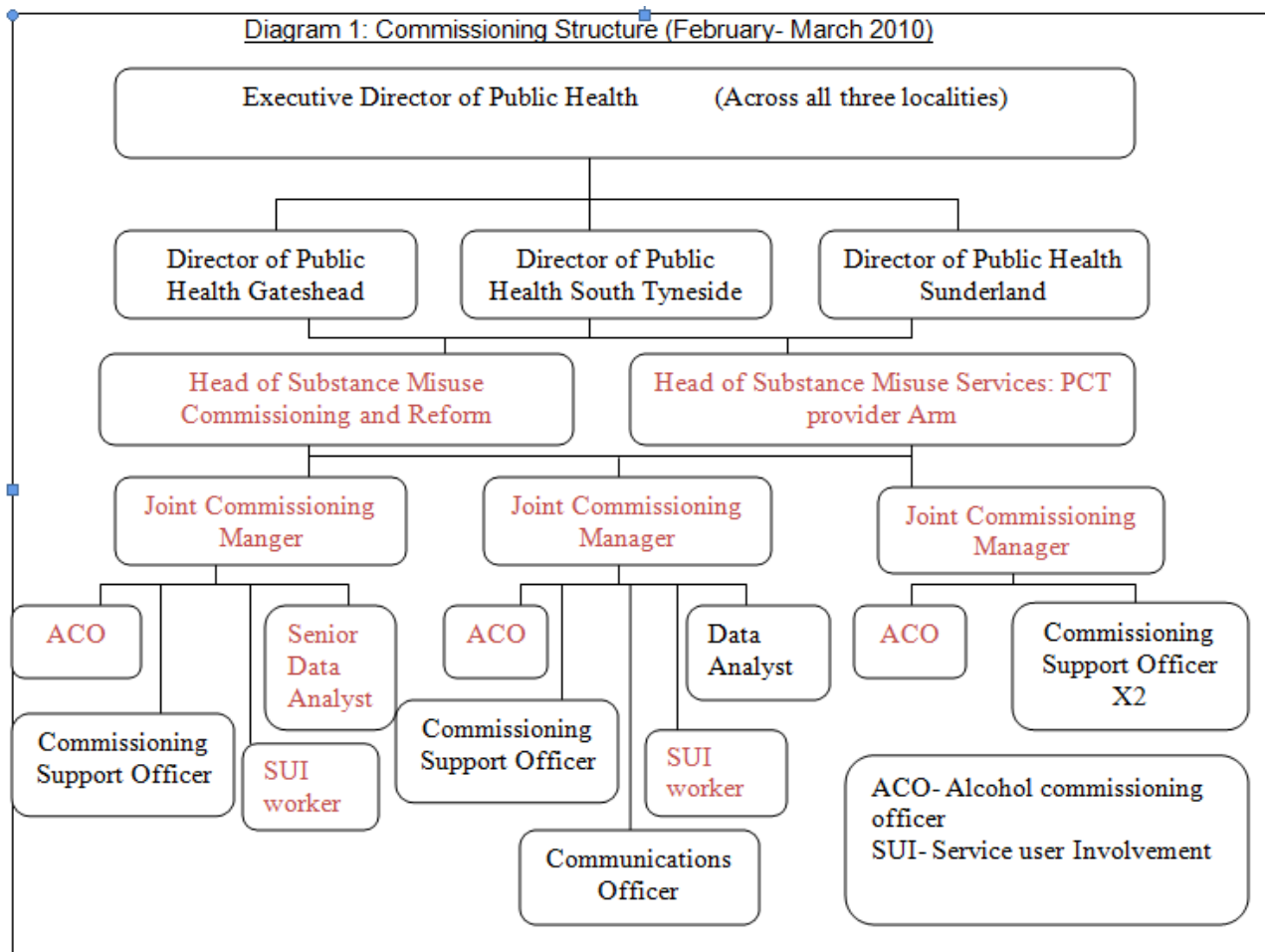


Figure 11: Commissioning structure (February- March 2010)

4.7.1.2 Alcohol service provider Interviews (phase 1: June- July 2010)

During phase 1, interviews were conducted with alcohol service providers located within the geographical boundaries of NHS X. An alcohol service directory was available covering the area of NHS X. A table was devised to categorise services by their tier of service provision, voluntary/third sector or statutory status and location and can be seen in table 7.

Service	Tier of provision	Status	Location
A	2 & 3	Voluntary/third sector	Boroughs A, B & C
B	2	Voluntary/third sector	Boroughs, A, B & C
C	4	Private Company	Available in all three boroughs Located Borough A
D	3 & 4	Voluntary/third sector	Available in all three boroughs Located Borough C
E	4	Voluntary/third sector	Available in all three boroughs Located Borough B
F	3	Community Interest Group	Borough A
G	2	Voluntary/third sector	Borough A
H	3	Statutory	Borough A
I	2	Voluntary/third sector	Borough B
J	3	Statutory	Borough B
K	3	Statutory	Borough C
L	2 & 3	Voluntary/third sector	Borough C

Table 7: Service provider respondents

The directory provided details of each alcohol service (n=16), the location and contact details. The alcohol commissioning officers in each locality provided the names of service managers to enable a direct line of communication. Maximum variation sampling was used to ensure a mixture of services from both voluntary/third sector and statutory agencies and preventative, curative and rehabilitative services. Furthermore, services were recruited from each of the three boroughs within the NHS catchment area. For the alcohol services that spanned all three boroughs for example; service A and B, the regional manager was contacted to provide an overview of the services in all three boroughs. 12 services were deemed eligible however, when contact was initiated it became evident that one participant managed two of the statutory services. Out of the 11 potential interviews, 10 participants agreed to take part in the research, only one manager refused due to current 'staffing problems' within their agency.

4.7.1.3 General practitioner interview (phase 1: August- December 2010)

Interviews were also conducted with General Practitioners (GPs) located within the geographical boundaries of NHS X. A GP who was research active and a substance misuse 'champion', volunteered to act as a gatekeeper in the recruitment of GPs. Due to the nature of the research (commissioning and alcohol), the gatekeeper provided contact details of GPs who were research active and had a special interest in alcohol and/or commissioning. If the proposed GPs were unable to participate on a couple of occasions they identify further colleagues who may be willing to engage in the research, resulting in a snowball sampling technique being used. 15

participants were approached, nine GPs refused to participate due to time commitments and/or lack of specialised knowledge regarding the research area, resulting in six GPs agreeing to participate and completing an interview.

4.7.1.4 Commissioning dyads/triads (phase 2: April 2011)

This phase of data collection occurred 13-14 months after the original commissioning interviews and acted as an authenticity check for the findings so far. Due to restructuring within the commissioning teams, numerous organisational changes had occurred; the new alcohol commissioning structure is shown in Figure 12. The 'key members' of staff (n=9) were identified by the original gatekeeper used in phase 1 of data collection and were approached, eight agreed to participate in the interviews. One participant was unwell on the day of the scheduled triad interview and was unable to participate. Therefore, interviewees (n=7) consisted of three joint commissioning managers and four commissioning officers (four participants being interviewed for a second time).

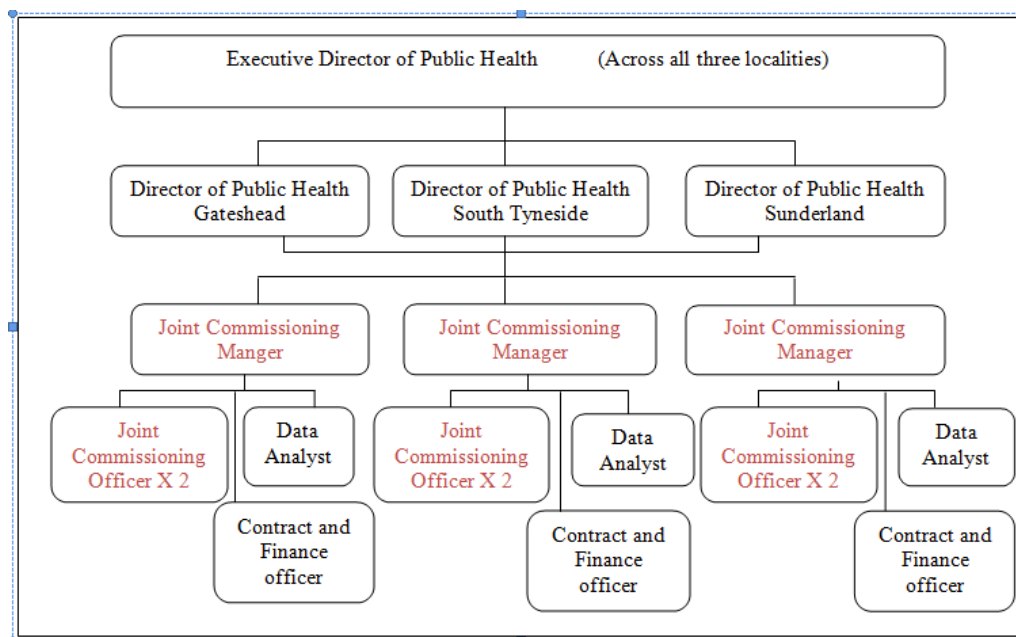


Figure 12: Commissioning structure (April 2011)

4.7.1.5 Verification Interviews (Phase 3: July 2014)

This final phase of data collection involved conducting interviews as an authenticity check for the findings, to capture how the significant changes introduced by to the Health and Social Care Act 2012 had impacted on stakeholder involvement in alcohol commissioning and to gain further information identified as missing from the

first two phases of data collection. The purpose of this phase was to re-interview as many participants as possible. The aim was also to approach individuals within significant positions within the new commissioning structure inclusive of Directors of Public Health and alcohol leads within the newly established Clinical Commissioning Groups. Purposive sampling was used to identify potential participants. The sampling frame is illustrated in table 8.

Potential participant	Contacted	Outcome
Director of Public Health in all 3 Localities	Yes	Declined- Redirected to LA Drug and Alcohol Commissioner
CCG Drug and Alcohol Lead in all 3 localities	Yes	Declined- Redirected to LA Drug and Alcohol Commissioner
LA Drug and Alcohol (Public Health) Commissioner Area A	Yes	Interviewed
LA Drug and Alcohol (Public Health) Commissioner Area B	Yes	Interviewed
LA Drug and Alcohol (Public Health) Commissioner Area C	Yes	Interviewed
Service C	Yes	Interviewed
Service K	Yes	Interviewed
Service A, B, D, E, F, G, H, I, L	No	No longer exist/Different Manager in role
GP 1 and 6	Yes	Interviewed
GP 2,3, 4 and 5	Yes	No response

Table 8: Potential participants

Service users are not included in the sample as it was not possible to re-interview service users as contact details were not collected during the initial focus groups.

The Director of Public Health was contacted in each of the 3 localities; the DPH in each locality declined to participate and recommended the local authority commissioner with responsibility for drugs and alcohol. This is the same scenario as when the DPHs were contacted at Phase 1 of data collection. The Clinical Commissioning Group (CCG) for each locality was contacted and asked to identify a specific drug and alcohol lead within their area. One CCG stated that the position was vacant and the other two CCGs again recommended to the Local Authority commissioner with responsibility for Drugs and Alcohol. For both the DPH and CCGs

it was stated that the local authority commissioners would have the necessary 'specialist' knowledge to take part in an interview regarding alcohol commissioning.

Interview participants consisted of 3 local authority commissioners with responsibility for drugs and alcohol; all 3 were the previous joint commissioning managers under the PCT and had therefore been interviewed at phase 1 and phase 2 of this research.

Furthermore, as the table highlights, due to the significant organisational changes that had occurred only limited participants were still available. Only 6 of the original 10 alcohol services were still in existence and only 2 services still had the same manager, therefore these 2 participants were contacted and re-interviewed.

The original 6 GPs were contacted and 2 participants replied and agreed to partake in the research again. Therefore, 7 participants were interviewed at this stage of data collection.

The participants recruited throughout the entire data collection process are presented in table 9 below.

Role/Participant	Identifier	Phase of data collection
Commissioner 1	ID1, Female, PCT Commissioner ID1, Female, PCT Commissioner	February- March 2010- Phase 1 Re-interviewed April 2011- Phase 2
2	ID2, Female, PCT Commissioner	February- March 2010- Phase 1
3	ID3, Female, PCT Commissioner ID3, Female, PCT Commissioner	February- March 2010- Phase 1 Re-interviewed April 2011- Phase 2
4	ID4, Male, PCT Commissioner ID4, Male, PCT Commissioner ID4, Male, LA Commissioner	February- March 2010- Phase 1 Re-interviewed April 2011- Phase 2 Re-interviewed July 2014- Phase 3
5	ID5, Male, PCT Commissioner	February- March 2010- Phase 1
6	ID6, Female, PCT Commissioner ID6, Female, PCT Commissioner ID6, Female, LA Commissioner	February- March 2010- Phase 1 Re-interviewed April 2011- Phase 2 Re-interviewed July 2014- Phase 3
7	ID7, Male, PCT Commissioner	February- March 2010- Phase 1
8	ID8, Male, PCT Commissioner	February- March 2010- Phase 1
9	ID9, Male, PCT Commissioner	February- March 2010- Phase 1
10	ID10, Male, PCT Commissioner	February- March 2010- Phase 1

General Practitioner 1	ID11, Male, GP ID11, Male, GP	August- December 2010- Phase 1 Re-interviewed July 2014- Phase 3
2	ID12, Male, GP	August- December 2010- Phase 1
3	ID13, Female, GP	August- December 2010- Phase 1
4	ID14, Male, GP	August- December 2010- Phase 1
5	ID15, Male, GP	August- December 2010- Phase 1
6	ID16, Male, GP ID16, Male, GP	August- December 2010- Phase 1 Re-interviewed July 2014- Phase 3
Service Provider 1	ID17, Male, Service Provider	June- July 2010- Phase 1
2	ID18, Female, Service Provider	June- July 2010- Phase 1
3	ID19, Male, Service Provider	June- July 2010- Phase 1
3	ID20, Female, Service Provider	June- July 2010- Phase 1
4	ID21, Male, Service Provider ID21, Male, Service Provider	June- July 2010- Phase 1 Re-interviewed July 2014- Phase 3
5	ID22, Male, Service Provider	June- July 2010- Phase 1
6	ID23, Female, Service Provider	June- July 2010- Phase 1
7	ID24, Female, Service Provider	June- July 2010- Phase 1
8	ID25, Female, Service Provider	June- July 2010- Phase 1
9	ID26, Female, Service Provider	June- July 2010- Phase 1
10	ID27, Female, Service Provider ID27, Female, Service Provider	June- July 2010- Phase 1 Re-interviewed July 2014- Phase 3
Service User Focus Group 1	ID28, Male, Alcohol Service User	August- September 2010- Phase 1
2	ID29, Female, Alcohol Service User	August- September 2010- Phase 1
3	ID30, Female, Alcohol Service User	August- September 2010- Phase 1
4	ID31, Male, Alcohol Service User	August- September 2010- Phase 1
5	ID32, Female, Alcohol Service user	August- September 2010- Phase 1
6	ID33, Male, Alcohol Service User	August- September 2010- Phase 1
7	ID34, Male, Alcohol Service User	August- September 2010- Phase 1
8	ID35, Female, Alcohol Service User	August- September 2010- Phase 1
9	ID36, Male, Alcohol Service User	August- September 2010- Phase 1
10	ID37, Male, Alcohol Service user	August- September 2010- Phase 1
11	ID38, Male, Alcohol Service User	August- September 2010- Phase 1
Service User Focus Group2	ID61, Female, Alcohol Service User	August- September 2010- Phase 1
2	ID39, Female, Alcohol Service User	August- September 2010- Phase 1

3	ID40, Female, Alcohol Service User	August- September 2010- Phase 1
4	ID41, Male, Alcohol Service User	August- September 2010- Phase 1
5	ID42, Male, Alcohol Service User	August- September 2010- Phase 1
6	ID43, Female, Alcohol Service User	August- September 2010- Phase 1
7	ID44, Female, Alcohol Service User	August- September 2010- Phase 1
8	ID45, Male, Alcohol Service User	August- September 2010- Phase 1
9	ID46, Male, Alcohol Service user	August- September 2010- Phase 1
10	ID47, Male, Alcohol Service User	August- September 2010- Phase 1
11	ID48, Male, Alcohol Service User	August- September 2010- Phase 1
12	ID49, Male, Alcohol Service User	August- September 2010- Phase 1
Service User Focus Group3	ID50, Male, Alcohol Service User	August- September 2010- Phase 1
2	ID51, Female, Alcohol Service User	August- September 2010- Phase 1
3	ID52, Female, Alcohol Service User	August- September 2010- Phase 1
4	ID53, Female, Alcohol Service User	August- September 2010- Phase 1
5	ID54, Male, Alcohol Service User	August- September 2010- Phase 1
6	ID55, Male, Alcohol Service User	August- September 2010- Phase 1
7	ID56, Male, Alcohol Service User	August- September 2010- Phase 1
8	ID57, Female, Alcohol Service User	August- September 2010- Phase 1
Commissioning Focus Group 1	ID58, Female, Commissioner ID58, Female, LA Commissioner	April 2011- Phase 2 Re-interviewed July 2014- Phase 3
2	ID59, Female, PCT Commissioner	April 2011- Phase 2
3	ID60, Female, PCT Commissioner	April 2011- Phase 2

Table 9: Research participants

4.7.2 Focus Groups

4.7.2.1 Service user focus group (phase 3)

In relation to service users, a focus group took place in each of the three boroughs within the geographical boundaries of NHS X. Service users (n=31) were invited to participate regardless of the tier of service (prevention, cure or treatment) they had accessed to receive an alcohol intervention/treatment. The service user involvement officer in each locality acted as a gatekeeper to help facilitate access to this potentially hard to reach group of individuals. They were provided with a clear inclusion criterion outlined as individuals who were: 18 years old or over, alcohol is their primary substance misuse problem, they were willing to be recorded and

participants could provide informed consent to participate. The service user involvement officer organised the location of the groups and contacted the alcohol treatment providers in each locality providing the appropriate details of the group and asking each service to identify 2-3 volunteers who were willing to participate in the focus group. Further details regarding the time, date, location and venue of the focus groups were provided by the gatekeepers and alcohol service providers alongside the offer of reimbursement of travel expenses and a contact number in case anybody required further details. Participants were provided with the option of contacting the researcher prior to the focus group (none of the participants did this) or alternatively they were advised they could just turn up on the day.

The location of the groups was carefully considered to enable easy access for participants therefore locations central to the town centre were chosen in each locality. Each venue had regular public transport links and car parking was available (travel expenses were reimbursed when a valid receipt was produced). All of the chosen venues were wheelchair accessible, had toilet amenities available and had tea and coffee making facilities. At the start of each group, participants were verbally provided with information stating the purpose of the research and specific themes that would be discussed and participant information sheets were made available upon request (appendix 1). Ground rules were discussed and agreed by all participants and all individuals completed a consent form (appendix 3). A topic guide was used within each group (appendix 8). At the end of the focus group a closing round was carried out to ensure all participants were 'safe' to leave the group and participants were advised that they would be offered an opportunity to debrief after completing the group interview. Prior arrangements had been made for such a facility to be available. All of the groups were audio taped and participants were offered the option of contacting the researcher if they desired to discuss anything on a one to one basis although no one actually took this offer up.

4.8 Methods of data analysis

The main principles of Grounded Theory (GT) were chosen to guide the data analysis. Bowling(2002) identifies that grounded theory refers to “a process of discovering theory from data that have been systematically worked out in relation to the data during the course of the research”(Bowling 2002: 125).The 'groundedness'

of this approach results from the researcher's commitment to analyse what has been observed within the data and rather than being restricted to preconceived hypotheses to remain open to unanticipated directions (Visram 2011). Grounded theory was chosen within this thesis as this perspective acknowledges that ideas and assumptions about the research topic are not put aside, but are instead used to better understand the process being studied. According to Henwood and Pidgeon (1994) the aim of a grounded theory approach is "the production of a meaningful account, which knits together the multiplicities, variations and complexities of participant's worlds"(1994: 231). Lingard (2008) argues that grounded theory is appropriate when studying process questions about participants changing experiences over time. Therefore, this approach was felt to be the most suitable in meeting the study aims and objectives due to this research exploring the process involved within alcohol commissioning.

Given that the research was funded by the NHS, there was an expectation that the findings were seen to be useful and transferable to the commissioning team. A grounded theory approach enabled the research to be responsive to the adapting situation within the NHS and the research was driven by the data therefore the final theory would provide a 'good fit' to the situation being explored. The aim was that the emerging theory 'makes sense' and that it would be recognisable that the theory is derived from real data and real people to which the reader can relate (Bryant and Charmaz 2007). The main advantages of using the principles of grounded theory within this thesis is that there is a focus on practice and the explanations provided will be 'grounded in reality'.

However, grounded theory has been accused of being unnecessarily strict in its application to a research subject. Within this research not all of the principles of grounded theory were adhered to as outlined by the original Glaser and Strauss version. Traditional grounded theory suggests that researchers do not approach their data collection and analysis with pre-existing beliefs. Glaser and Strauss assert that prior theory has no place in directing the research planning or conduct, since it might prejudice the research conduct. Whereas Miles and Huberman (1994) argue that this is a simplistic assumption to make as all researchers undertaking a piece of fieldwork will have some 'orientating ideas'. This research therefore adopted

Charmaz's(2006) constructivist grounded theory. Constructivist grounded theory, allowed flexibility to the approach and provided an opportunity to make each group of participants' perspectives explicit which is pivotal in such a multi perspective issue such as commissioning.

According to Charmaz(1995: 28) there are six basic characteristics of grounded theory:

1. Simultaneous involvement in data collection and analysis phases of research
2. Creation of analytic codes and categories developed from the data, not from pre-conceived hypothesis
3. The development of middle-range theories to explain behaviour and processes
4. Memo making, that is, writing analytic notes to explicate and fill out categories
5. Theoretical sampling (to check and refine categories)
6. Delay of the literature review.

Of the above characteristics attributed to grounded theory, points 1-5 were followed, however, the research departed from the last point in part.

The role and place of a literature review in grounded theory research often causes debate. Glaser and Strauss promote conducting a literature review after conducting data analysis, whilst other authors argue a literature review should occur before developing research categories. McGee, Marland and Atkinson(2007) claim that arguments against conducting a literature review before developing research categories include; the focus being generated from the literature rather than emerging data and assumptions being made from the pre-conceived information amongst others. However, Layder(1998)emphasises that the contribution of a piece of grounded theory research should be seen as cumulative rather than isolated. Layder continued to argue that it is his belief that it is not possible to approach research in a theory neutral manner. Although McGee et al make potentially valid observations, due to my practitioner background and my adherence to interpretivism and social constructionism, assumptions were already present about the research area, therefore to come with a blank canvas would not be possible. It is due to this belief that this thesis departed from 'traditional' grounded theory and a preliminary literature review was conducted within the early stages of my research. It would not

have been appropriate to ignore the literature that already exists as dismissing previous theory and work ignores good ideas that may help to inform the project. Furthermore, conducting a literature review before developing research categories allowed a justification for the study to be sought (identified by gaps in the literature) and the researcher could approach the research open minded but not empty headed. Although an initial literature review was conducted prior to data analysis, it is important to acknowledge that the literature review itself was iterative and evolving throughout the research period and the emphasis on relevant literature altered as the commissioning context changed and new themes emerged from the data.

4.9 Transcribing data

The interviews and focus groups were transcribed verbatim and research memos kept throughout the data collection process provided the data for analysis. All transcriptions were given an identifier, so that the participants' details were kept anonymous. Each transcription followed a set transcription guide (appendix 11); each line of data was numbered and details such as laughter were included in the transcripts to provide additional context.

4.9.1 Data coding

As identified above, the main Grounded Theory principles of simultaneous data collection and analysis, the construction of analytic codes and categories, the constant comparative method within analysis and memo writing were adhered to within the data analysis. Thematic analysis was undertaken. As Hammersley and Atkinson (1995) stated, the analysis of the qualitative data is an interactive and iterative process undertaken throughout the research study. Data was analysed initially by hand, with each transcript being printed and any interesting, key or recurring concepts were highlighted. Data was inputted into NVivo. NVivo is a computer software package used for qualitative research, used to help classify and sort information. However, in this thesis, NVivo was used purely as a data management tool; the majority of the data analysis took place in written and visual form. NVivo helped to ensure that a systematic and transparent approach to analysis was taken (Weitzman and Miles 1995). Although NVivo was only used to facilitate the data analysis, the free node maps could be made available to provide independent researchers with an insight into how categories/themes were established. The

analysis used a deductive approach and, in line with grounded theory, rather than approaching the research with a pre-determined theory already in place, thematic analysis allowed the arising themes to be identified and explored during the analysis of data. Memos were used to document any ideas, questions or hunches that arose and helped to spark fresh ideas and develop ideas further. The second step of analysis involved 'focused coding' in which the most significant and the most frequent codes were used to sift through the available data. Once identified, quotes were used to highlight similarities and differences in the data and therefore, either evidence or challenge the emergent concepts. The key concepts were categorised into themes. These were constantly reassessed and shaped in line with the constant comparison element of the grounded theory approach as new data emerged. Corbin and Strauss (2008: 65) describe constant comparison as "the analytic process of comparing different pieces of data with similarities and differences". A constant comparison process provided an opportunity to identify and examine categories as they emerge and each item for analysis was compared with the results of the data to establish analytic categories. Following the initial analysis by hand, mind maps were created to visually show the links between ideas.

4.10 Chapter summary

The research relied on multiple sources of evidence, utilising a case study research design and employing the methods of semi-structured interviews and focus groups. Interviews and focus groups were conducted with commissioners, alcohol service providers, alcohol service user and general practitioners in an attempt to gain a holistic view of the current situation surrounding commissioning practices and available alcohol service provision. The main themes from the research data are presented in Chapters 5 and 6.

Chapter 5 : ‘Understanding’ stakeholder involvement: stakeholders’ knowledge of and experience in Commissioning

5.1 Introduction

This chapter is the first of 2 results chapters and examines a number of different aspects of stakeholder involvement in commissioning. This chapter presents a rich description of participants’ perceptions of who they understand stakeholders to be and what stakeholders can contribute to alcohol commissioning. It proceeds to examine participants understanding of commissioning. First, it explores stakeholder knowledge *of* commissioning. Second, it describes the extent of stakeholder experience of being involved *in* commissioning. Third, it examines the level of motivation and desire participants displayed to be involved in commissioning activities. Verbatim quotes are used to evidence these findings.

This Chapter and Chapter 6 draw on findings from all three phases of data collection, which were identified in Chapter 1 (figure 3). The phase of data collection is identified with each quote as this helps to contextualise the data and also helps to give reasons for the changes in opinion voiced by certain participants depending on the environment they were working within. The information presented in this chapter is descriptive in nature and the overarching themes identified within this chapter will be discussed in Chapter 7.

An important acknowledgement to make at the beginning of the findings chapters is that despite all stakeholders being asked specifically about ‘alcohol service’ the majority of participants referred to ‘substance misuse’ agencies as all of the providers in the area offered services for both alcohol and drug service users and practitioners worked with individuals regardless of the presenting substance. The term ‘substance’ was used to encompass both sets of service users (drugs and alcohol) and, despite probing many participants still made reference to the services generically. In addition, despite questions making reference to all tiers of service inclusive of tier 1, Screening and Brief Intervention (SBI), aside from general practitioners acknowledging that SBI was now used more frequently within their practice and commissioners explaining that they have invested in SBI, the majority of participants focused on the heavy end of alcohol treatment. For service providers this is not surprising as 5 out of the 12 service providers interviewed only provided

tier 3 and 4 services (alcohol detox and residential treatment). Furthermore, the majority of service users that chose to attend the focus groups had been in treatment on multiple occasions and many had experienced alcohol related hospital admissions and/or had undertaken an alcohol detox emphasising a level of dependency.

5.2 Who are stakeholders in alcohol commissioning?

Within the first 2 phases of data collection when the term 'stakeholder' was used by participants, it was made predominantly with reference to alcohol service users. The term was not explored further at these stages, but was the focus of further investigation within phase 3 of data collection. After probing, all participants showed an appreciation regarding the diversity of who a stakeholder could be. Some participants provided extensive lists of potential stakeholders who should be involved in the commissioning of alcohol interventions, the quote below demonstrates this well:

"I think they (stakeholders) should be service users, they should be carers. I think they should be the commissioners, I think the other providers. Then I also think there should be a network of other stakeholders who are affected. Obviously you've got the core in there but externally to that you've got police, probation; you've got local authority, community safety services. You've got children's services, you've got adult services and you've got mental health services around that."

ID21, Male, Service Provider, Phase 3

GPs also highlighted the sheer numbers of potential stakeholders that should be consulted. The focus was more health related with specific reference being made to primary and secondary care providers however, the principle remained the same that the spectrum of stakeholders is vast. Participant ID11 stated:

"All the voluntary sector, the third sector; that's a big blanket. Patients, carers, clinicians, primary, secondary care, local communities."

ID11, Male, General Practitioner, Phase 3

This participant continued to state *"for the whole process of alcohol to work, you can't have anyone missing from the chain"* (ID11, Male, general practitioner, Phase 3) again emphasising the need for a broad and comprehensive range of

stakeholders to be involved in the consultation process surrounding alcohol commissioning.

Commissioners also provided extensive lists of who should be involved; in addition commissioners also provided a very 'catch all' definition of what stakeholder involvement should consist of:

"In the context of commissioning, anybody that's impacted by what you plan to do through commissioning of services or influencing services."

ID4, Male, Commissioner, Phase 3

A more autocratic method of working was implied by one commissioning participant, she stated "*obviously we are the main stakeholder because we are commissioning the service*" (ID58, Female, Commissioner, phase 3). This suggestion of a dictatorial way of commissioning had not been implied by any of the other participants involved in this phase of data collection.

5.3 What is the stakeholders' role in alcohol commissioning?

A further theme emerging was related to what participants felt stakeholders could contribute to the commissioning of alcohol services. Each participant involved in phase 3 articulated how stakeholders could strengthen the commissioning process. Commissioner ID4 provided an insightful reason as to why it is important to involve stakeholders in the commissioning process, he stated that:

"From a commissioning perspective, it's quite easy to think that you've come up with the right answer to things, and therefore, you can sometimes be too close to it, to understand well, actually, if you'd looked at it from a completely different point of view, you might've come up with something different. So I suppose as a whole, it's one, bringing in other specialist knowledge, which you may or may not have. And also, allowing challenge to your own assumptions."

ID4, Male, Commissioner, Phase 3

The above quotes portray an approach inclusive of stakeholders regardless of their status or standing within society.

Despite the majority of participants providing extensive lists of who constitutes stakeholders, when exploring what stakeholders can contribute to the process,

participants tended to describe singular groups of stakeholders. Clinicians primarily described stakeholders in terms of service users/patients. It was stated that they were important to the commissioning process as they could contribute due to their own personal experiences of service. A GP participant explained that “*they bring all their perspectives of the different services and their experiences they have*” (ID11, Male, General Practitioner, Phase 3). Furthermore, service providers also focused on service users and carers, as illustrated in the following quote:

“I think they do bring a different perspective and I think that's really important and I think service users and carers are probably underrepresented in terms of getting involved in the commissioning process.”

ID21, Male, Service Provider, Phase 3

Furthermore, commissioners focused on providers of alcohol interventions as the main stakeholders, making specific reference to providers contributing their skill and understanding of working ‘face to face’ with clients. The following quote makes the point:

“I think they bring a completely different level of experience and knowledge. I think that's what it is. We can be as skilled as we like around commissioning. We can be as knowledgeable as we possibly can be around the thematic area, but I don't do face to face work with clients.”

ID6, Female, Commissioner, Phase 3

5.4 Stakeholder Knowledge of commissioning

The PCT/ local authority commissioner participants conveyed up to date knowledge of the process involved and policy changes that had taken place. In addition, GP participants were also aware of commissioning policy due to the policy changes surrounding commissioning responsibility being transferred to CCGs (as discussed in Chapter 1). Surprisingly, the knowledge diminished among other participants with service providers and services users appearing to have little awareness of what the commissioning process involved. All participants alluded to their involvement in shaping service design, contributing to consultations and being involved in monitoring exercises all of which touch upon aspects of the commissioning process. However, they did not explicitly show an understanding of, or articulate an appreciation for the complete commissioning process inclusive of strategic planning,

procurement, monitoring and evaluation of providers. When specifically looking at the procedures involved in commissioning, only commissioning participants provided descriptive examples of what the process 'looked like'. This emphasised that the other stakeholders interviewed showed little awareness of the process in its entirety; rather they described examples of their intermittent involvement in commissioning activities.

5.4.1 The commissioners' perspective

Commissioners described a myriad of elements involved in their role highlighting the complexity of their position. Participants spent a large amount of time describing the commissioning process that they undertook. The definitions provided by all participants were succinct and, provided a very logical, almost textbook definition of commissioning as the following extract demonstrates:

"For me commissioning is about what is in the commissioning cycle, that's at the heart of what we do its about doing a needs assessment, looking at local need, looking at what we've got already and then looking at the resources we've got, how are they being spent, do they match what's in the needs assessment, are there any gaps, how can we realign things if necessary then putting that into place, making sure we've got the contracts in place and monitoring the budget, ensuring the money is going where it's supposed to and then again going back to reviewing all of that and starting the whole process again."

ID1, Female, PCT Commissioner, Phase 1

The majority of participants highlighted the cyclical nature of the commissioning role, the definitions provided implied a rational, linear sequence which does not reflect the 'messiness' and reality of commissioning. Historically, drug services received a ring fenced budget via the National Treatment Agency (NTA) requiring a strict regime to be followed *"thanks to the national treatment agency and the system that they gave us for commissioning, we were already operating a fairly comprehensive commissioning, annual commissioning cycle"* (ID4, Male, PCT Commissioner, Phase 1). The implication being that regardless of the commissioning policy being imposed, the same processes occurred, such as needs assessment, procurement and review. The majority of participants stated that they have worked in a consistent way over the last decade the quote below illustrates this well:

“It’s always been quite focused within substance misuse. I think more so than other areas....So that’s almost been an indelible pattern that’s been in place certainly for the last ten years that I’ve been working in, so within [REDACTED] that’s been consistent ways of working within substance misuse.”

ID8, Male, PCT Commissioner, phase 1

5.4.1.1 World Class Commissioning: A formalisation of good practice

At the time the phase 1 interviews were undertaken, the World Class Commissioning (WCC) framework was operational. All but one commissioning participant agreed that the WCC competencies had provided a positive framework to work within. Participants emphasised that a positive element of the framework was that the understanding of WCC as a concept was universal. The commissioning team commented that WCC had helped to clarify what was expected of commissioners and had aspired to raise the quality of commissioning that was being undertaken. They explained that it had been a formalisation of good practice and had provided a framework to aspire to as the following quote describes:

“World Class Commissioning is definitely the framework and the building block that we...we need to be using and I see it in the context of its world class, it’s universal. If something is class then it’s the best in its field.”

ID8, Male, PCT Commissioner, phase 1

Participants continued to explain that the WCC policy had provided “a common language and a common understanding and I think it’s raised the quality of commissioning” (ID5, Male, PCT Commissioner, phase 1). The understanding of commissioning concepts had increased and knowledge of what was expected from commissioners was enhanced therefore minimising scope for confusion within their role. Participants agreed that WCC had provided a recognised structure for commissioning, as the following extract demonstrates:

“I think if you want to commission a new service, you need to go through them and say well have we done this, have we done that?”

ID3, Female, PCT Commissioner, phase 1

The prescriptive framework described above clearly set out the different stages of the commissioning cycle and in terms of a process, WCC had provided commissioners with a step by step guide:

"I suppose in terms of a...a process I think it helps to understand where we should be headed to next. You've done this, you've done that, you've understood your local community, okay, commission your services then performance band your services and then obviously do the check again."

ID7, Male, PCT commissioner, phase 1

For individuals new to the commissioning role, having a distinct step by step model to follow had felt beneficial, providing additional reassurance of what was expected to be undertaken as part of their role. The quote below describes this well:

"You can see, so you can go right so right I know exactly sort of, I'm ticking the box for that competency by doing this piece of work here."

ID2, Female, PCT Commissioner, phase 1

However, despite the positives attributed to WCC, in stark contradiction some participants also described the policy as reducing the levels of autonomy and opportunity for innovation was minimized due to adhering to a prescriptive step by step guide. The use of terms such as '*do the check again*' and '*ticking the box*' implied a mechanical method of working which was not reflective of the complicated role that commissioners performed. A commissioner commented that the WCC framework had introduced an NVQ feel to their practice.

"It's pretty much to me; it was like the WCC stuff was like an NVQ. We had to say I've done this, I've done that, where's the evidence, Oh there it is."

ID7, Male, PCT Commissioner, phase 1

5.4.1.2 *Changing commissioning policies: Actual change or just rebranding?*

All commissioning participants reported that the WCC framework had standardised practice and stated that it had driven up the quality of commissioning. Paradoxically when re-interviewed for phase 2 (13 months later) the majority of participants questioned whether in reality commissioning had changed substantially or whether it

had just been rebranded. When completing the dyad/triad interviews; participants inferred that the emergence and then the disappearance of WCC had created little disturbance within the PCT commissioning teams and successor structures. Commissioning participants had initially described the WCC policy in positive terms, using expressions like *'raised quality of commissioning'* as identified above. Nevertheless, with hindsight participants emphasised that despite the substantial focus that had been placed on the launch of WCC making it more recognisable in policy terms, in actuality it was just 'rebranding' of the previous commissioning process that the alcohol team had been working to. Commissioning participants acknowledged that many of the positive elements of the framework could be transferred to whichever commissioning policy was currently being adhered to, as the quote below demonstrates:

"I wouldn't say it has altered hugely in the time that I've been here but in a sense this style of commissioning has become more of interest to the primary care trust."

ID4, Male, PCT Commissioner, phase 2

By April 2011, the WCC programme had officially been abolished. Its demise had limited impact on the 'back office' functions of commissioning as the needs assessment still needed to be completed, consultations undertaken and services procured. In response to whether there had been much impact following the demise of WCC, the resounding response was:

"World class commissioning as an idea might not be as strong any more, but I think the principles were there before, because they came through very strongly as well from the work that we did with the NTA and I don't think they've gone away."

ID1, Female, PCT Commissioner, phase 2

Despite the previous praise given by most commissioning participants to the WCC process and its ability to 'professionalise' commissioning, following its abolition its attributes were now minimised. The majority of those participants now acknowledged that the principles of commissioning remain consistent regardless of the policy that is imposed, as can be seen in the following quote by ID4:

“World class commissioning was just a brand wasn’t it for really the things that are still core to exactly what we do so..... So although....that’s often the way it’s been talked about it felt like a bit well that’s yesterday’s news and it’s now gone out the window it hasn’t really. None of the competencies and the techniques that we should use as a day to day method of doing things, none of that’s changed.”

ID4, Male, PCT Commissioner, phase 2

Commissioning participants emphasised that they were undertaking the same tasks and had the same commissioning responsibilities even though the WCC policy no longer existed. Furthermore, despite the positive factors attributed to WCC in the interviews in phase 1, once it was abolished all of the commissioning participants in this study described the adherence to WCC competencies as a distraction from their commissioning role.

By phase 3 of data collection a further transfer of commissioning responsibility into local authority had occurred. However, yet again, from the commissioners perspective little had changed regarding the commissioning process per se. When describing the impact of the transfer from PCT to LA it was stated: *“I think from the drug and alcohol perspective currently, it doesn’t appear to have impacted too much”* (ID58, Female, Commissioner, phase 3). Emphasising that the process changes had had minimal impact, the following statement was made:

“The processes remain the same, I would say, whether they’re called world class commissioning or...It’s a term that isn’t used and hasn’t been used for a long time now, but at the end of the day, it’s operating around a cycle with exactly the same principles.”

ID4, Male, Commissioner, Phase 3

Furthermore, commissioners stated that although policies had changed, WCC previously helped to establish the commissioning model currently used:

“We then went through that very structured period with the commissioning cycles and the guidelines and a lot of emphasis that was put on- I can’t remember what it was called now, that whole commissioning process (WCC). I now think that it’s now just become fundamental to what we do. So certainly in terms of the work that we do, it’s based on that commissioning model and that’s the way we carry out our business.”

ID6, Female, Commissioner, Phase 3

Nevertheless, having stated that the process and principles of commissioning alcohol services had not changed participants then often contradicted themselves by describing the levels of bureaucracy and rigour associated with commissioning since transferring to local authority:

“The council are very rigorous in terms of their approach to procurement and the commissioning cycle....I think a lot of the team we’ve struggled with the bureaucracy and what we need to go through to actually get anywhere....I think in [REDACTED] Council – we did go through processes in the PCT, it wasn’t just go and do it. I think the processes are a lot tighter and a lot stricter in the council.”

ID58, Female, Commissioner, Phase 3

Participants within the commissioning team perceived that the amount of scrutiny experienced working within the local authority was greater than the PCT scrutiny levels. They did however question whether individuals scrutinising their work had appropriate skill and knowledge to do so:

“The local authority is much more bureaucratic. Any contract over half a million would need to go to full cabinet for sign off, and that’s over the length of the contract.... The minute it starts to go to cabinet, then you get into the scrutiny. I’m not saying the scrutiny is wrong, but you’re potentially being scrutinised by people who don’t have the understanding of the service that you’re actually commissioning.”

ID6, Female, Commissioner, Phase 3

When commissioners considered the knowledge that other stakeholders may have, participants reflected that many stakeholders did not have a clear understanding of the processes involved, stating: *“No. I don’t actually think they do around the process”* (ID6, Female, Commissioner, phase 3). However, commissioners felt as though an in depth knowledge of commissioning was not necessary for stakeholders to be involved in the consultation process, as the following quote demonstrates:

“You don’t have to take somebody through an in-depth analysis of what a commissioning cycle is, so much as tell them how you’ve come to the point that you are, in terms of what you think need is, and what evidence you’ve used, how you would want to use their views, what may or may not come out the end of it.”

ID4, Male, Commissioner, phase 3

5.4.2 The General Practitioners' perspective

Crucially, it was due to the political interest in locating commissioning decisions with GPs and their local communities through CCGs, that each of the 6 GPs interviewed were aware of the commissioning changes that were taking place. GP participants were either directly involved in commissioning or were aware of their partners within the GP practice who were involved in commissioning services. The GPs interviewed agreed that, as frontline clinicians, they saw problems on a day to day basis and had an understanding of what was missing and what needed to be '*fixed*'. All GP participants demonstrated an awareness of commissioning policies, their commissioning experiences; both historical and current were explored and a strong theme that emerged was that of commissioning being 'a divisive process'.

5.4.2.1 A divisive process

The previous experiences and levels of involvement in historical commissioning processes were variable amongst GP participants. GPsexplained, that commissioning policies were 'divisive':

"I think it (GPFH) was divisive and I think it allowed within a population too many variables to arise, it wasn't equitable."

ID12, Male, General Practitioner, phase 1

The experience of being involved in past commissioning policies, and, the desire to become involved in CCG's created variable responses between GP participants. As one participant explained:

"My experience of GP fund holding was that as a GP trainee, I worked in 2 fairly politically motivated practices both of who found GP fund holding to be divisive and they didn't engage with it because of their political beliefs, so I was never tremendously, it was never presented to me in any sort of positive way."

ID13, Female, General Practitioner, phase 1

Focusing on more recent policies, the WCC process was not viewed favourably by GP participants. It was deemed to be time intensive and too much importance had

been placed on justifying work being carried out rather than the impact of interventions being commissioned. As the following quote demonstrates:

“The world class commissioning assessment. I thought it was an incredibly bureaucratic process that took a lot of time of the, primary care trust commissioners, they spent I would think probably 50 percent of the energy of the organisation went into proving the competencies, rather than actually doing the, the commissioning. ... And I’m not surprised that it’s been consigned to history. I think the actual competencies all make sense, I think what was wrong was the assessment process. If we have to, spend half of our time proving that we are competent, we’ll have lost the battle.”

ID15, Male, General Practitioner, phase 1

When discussing the effect of WCC being abolished, participants described experiencing limited impact on their day to day work as GPs. The following quote makes this point:

“We noticed no difference at all. If you talk to anybody in the practice apart from two people – two of the partners – they’d say: what’s that.”

ID16, Male, General Practitioner, phase 1

When describing the ‘future’ of GP involvement in commissioning, all participants voiced some concerns surrounding CCGs due to the complexity of the commissioning process. GP participants went on to explain that it was not just the complexity of the commissioning process but also the budgetary responsibility that will be incorporated into the role of CCG’s that would intensify the pressure that GPs will experience:

“I think the thing that brings, the down side of it is the budgetary responsibility that GPs then have. We are going to be accountable for the spend. Now we’ll be, we’re going to be dealing with hard budgets and that starts to get, get serious, as well as taking on the commissioning we’re taking on the sort of responsible officer roles, so Somebody’s going to lose sleep at night if the books don’t balance.”

ID15, Male, General Practitioner, phase 1

The above participant (ID15) was heavily involved in commissioning and therefore had a clear understanding and respect for the numerous tasks involved in the commissioning role. GP participants verbalised their levels of trepidation surrounding the future of commissioning.

5.4.2.2 Clinical Commissioning Groups: Passing the buck

For GPs a sense of uncertainty surrounded the policy changes and a feeling of 'passing the buck' to GPs regarding commissioning responsibility was expressed. For some GPs the prospect of undertaking economic activities such as rationing had the potential to detract from the doctor-patient relationship as the following quote highlights:

"I am extremely anxious about it; so with my cynical hat on I am worried that because rationing is going to have to probably become more explicit and overt, it's going to be GPs who are going to be seen as rationing."

ID13, Female, General Practitioner, phase 1

A further GP participant commented on levels of accountability being transferred to CCGs, emphasising the shift of responsibility away from central government as the following quote describes:

"I think it's a structure by the government to move responsibility and accountability to GPs away from central government."

ID16, Male, General Practitioner, phase 1

At phase 3 data collection, the transfer of commissioning responsibility to CCG's had occurred. Participants within GP practices stated that the number of iterations that had occurred regarding commissioning policies had led to confusion for many people surrounding who held commissioning responsibility, as the following quote shows:

"Well we've been through all the iterations of PCGs, PCTs, world class commissioning, then back to CCGs. It's been very confusing. I think there's very few people actually can follow the history of all the changes. Obviously the big recent split is a lot of commissioning's gone to public health in local authorities."

ID11, Male, General Practitioner, Phase 3

This participant continued to state that even after the transfer to CCG's had occurred, he still did not feel knowledgeable about commissioning:

"I probably feel slightly divorced from it, so I'd now be speaking more as a front line GP. As a front line GP, it still feels like a bit of a black box done elsewhere by other people. I think those other people still feel a bit remote. My partner here is chair of the CCG so I've got an insight into what happens at the CCG and I go to CCG meetings. Alcohol is more local authority and I suppose I don't know who those people really are and what's happening a lot."

ID11, Male, General Practitioner, Phase 3

Alongside the knowledge of commissioning policies and processes held amongst the research participants. A further area of discussion explored within all phase 3 interviews was whether the participants interviewed felt that *other* stakeholders had a clear understanding of what commissioning was and the processes involved when commissioning alcohol services. There was a general sense amongst participants at this stage that many stakeholders did not have a clear understanding of what commissioning entails:

"From a very basic level I don't think people, maybe it's just me, but I don't think people understand the commissioning process and all the practicalities of that. They don't understand that the role of commissioning."

ID21, Male, Service Provider, phase 3

The service providers interviewed within this phase, felt as though their colleagues, the providers of alcohol services had a good understanding of the commissioning process as they were involved in it due to services going out to tender. One participant commented that *"I think most of the services, the provider services; probably do because they've been a part of this whole process"* (ID27, Female, Service Provider, Phase 3). The same participant continued to make specific reference to alcohol service users, stating that she believed they had little understanding of commissioning and questioned the appropriateness of involving service users who were actively seeking current treatment:

“I think in terms of the service user, I don’t think they know. I don’t think they care. All they need is treatment. We get people caught up in things that they shouldn’t really have to focus on. I know there’s a big push for service user involvement and I’m all for that, but it’s like everything - the pendulum swings and we just go overboard with it really. A lot of these people that are involved need to focus on their own recovery.”

ID27, female, Service Provider, Phase 3

The other service provider interviewed at phase 3, was in agreement regarding service users being involved as stakeholders in commissioning. The participant implied that some service users accessing the ‘heavy end’ of treatment are not in a position to contribute as they are focusing on their own treatment and recovery, as illustrated in the following quote:

“I think the issues are that they are probably trying to resolve their problems rather than getting involved in trying to improve services.... People that possibly get involved and their opinions are getting involved in the standard commissioning process are at a different level of treatment or recovery journey”

ID21, Male, Service Provider, Phase 3

The two quotes above are making specific reference to individuals accessing alcohol treatment to address dependent drinking patterns; the same opinion may not be the same for individuals who are less severe drinkers such as harmful drinking or binge drinking or those accessing preventative services.

5.5 Stakeholder Experiences *in* Commissioning

This section explored stakeholders perceptions regarding their experiences and opportunities to be consulted regarding commissioning decisions. The following themes emerged: stakeholder consultation rhetoric or reality; the clinicians’ voice: is it being heard; and non-participation: choice or oppression.

5.5.1 Stakeholder involvement: Rhetoric or reality- A commissioner’s perspective

Even with regard to the commissioning team who hold ultimate responsibility for commissioning decisions, discrepancies arose regarding whether collaborative decision making actually occurred. Acknowledgement was made by commissioners that decisions should include consultation with all members of the commissioning

team. In reality, participants described one member of the commissioning team as driving the decisions forward and being influential in the direction of travel undertaken, due to their senior status. Participants described a contradiction with regard to who was involved in decisions and who should be involved in decisions, as illustrated in the following quote:

“Well there are two answers to that really, there’s who in principle should be involved and then there’s who actually makes the decisions. In principle, I suppose it should be all partners that are involved in the decision making. It would include people like the local authority, but also service users and carers as well as you know other services....I would say that is more, certainly around alcohol I felt that the main decisions have come down from [REDACTED] [REDACTED] head of substance misuse and sort of from his level he’s very much led the whole alcohol agenda.”

ID1, Female, PCT commissioner, phase 1

Despite having multi agency forums to take decisions to, commissioners explained that it was a few key players within the commissioning team that directed and controlled the decisions being made. Commissioning participants who were lower in the ‘chain of command’ were prepared to accept that colleagues with more power would influence the decisions. As one interviewee explained:

“It would be well [REDACTED] heads it, well he’s just been promoted to the strategic lead and then there’s [REDACTED] our commissioning manager so it’s mainly those two.”

ID2, Female, PCT commissioner, phase 1

A lack of autonomy was described by many members of the commissioning team, with participants explaining that commissioning managers dictated which services to commission. The high number of imposed decisions made it harder for participants to draw on local knowledge and design a treatment system that reflects the ‘local flavour’. The following quote captures this well:

“you know [REDACTED] come along and said right we’re commissioning Service F to do this across all 3 areas and when they say actually in the past we haven’t felt that they are the right service for our area, yes they might work well in other areas erm but we didn’t feel they provided what our population needs but [REDACTED] saying we are going to have equality across all three areas.”

ID1, Female, PCT Commissioner, phase 1

When commissioners were discussing decisions there was a resounding sense that even as commissioners, who are theoretically influential within the decision making process, the actual final choices made were enforced by senior members of the commissioning team, as two interviewees commented:

“I think to a certain extent we at the time were quite influenced about what was in other areas and I think on various levels the hospital project, yes I think it’s worked out but I think we were influenced in some way about what providers we had in.” ID3, Female, PCT Commissioner, phase 2

“Almost instructed really.” ID6, Female, PCT Commissioner, phase 2

Participants used terms such as ‘*instructed*’ and the level of top down guidance with regard to commissioning decisions being made was obvious again giving the perception of a lack of autonomy and disempowerment of more ‘junior’ members of the team.

Overall, members of the commissioning team acknowledged that multiple perspectives should be taken into consideration when making commissioning decisions, inclusive of clinicians and patients/members of the public. However, this created contrast to the autocratic approach described above. By default if decisions are imposed even on members of the commissioning team, it implies that other forms of stakeholder involvement would be tokenistic by definition due to the limited scope to influence the commissioning process.

Despite the seemingly limited scope for influence on decision making, some participants expressed the view that the level of engagement with stakeholders inclusive of service users had been effective and ongoing. The following quote explains this:

“I mean the positive thing is I mean not just once or twice a year we are constantly engaging with users of services with the providers themselves to get a gauge and a feel for what’s what and understand what the real nature of demand and the need is. So from that perspective there’s...there’s fairly healthy connectivity with that.”

ID8, Male, PCT Commissioner, phase 1

Additionally, participant ID2 emphasised the need for outreach when consulting with service users therefore increasing the engagement opportunities as identified below:

“I don’t think it’s right interviewing everybody that’s in treatment, I don’t, you’ve got to find those that are actually aren’t.”

ID2, Female, PCT Commissioner, phase 1

However, in stark contradiction to the optimistic ‘all inclusive’ statements made by some commissioners, other commissioning participants felt that on occasions stakeholder involvement had been tokenistic and regarding service users, only accessed a captive audience of individuals already involved in treatment. As the quote below highlights, one participant implied that service users were ‘cherry picked’ to be involved in consultation events:

“It was mostly through just word of mouth really and through staff. I suppose it is difficult to say it was a random sample because it probably wasn’t, and I was a member of staff in one of the treatment agencies at the time and you knew which service users were more likely to get involved, so you would just ask those, it certainly wasn’t a case of every service user being asked I think it was the ones that people thought would respond well to it. That was more what we were encouraged to do than blanket invite...I’m not sure that there was anybody who wasn’t already involved in services to some extent coz I think they were all mainly recruited through services.”

ID1, Female, PCT commissioner, phase 1

Whilst a mainly positive portrayal of service user involvement was provided by most commissioners, one participant implied that they felt in their opinion that consultation did not occur with alcohol service users at all:

“We consult the local communities but I think again for that aspect it was never really the end user. As far as I’m aware we never really asked those individuals and we don’t really ask the alcohol user at the moment.”

ID7, Male, PCT Commissioner, phase 1

Whilst the proactive engagement of public and patients is reported as being a focus of commissioning, some interviewees seemed to be resigned to gaining a ‘substandard’ level of involvement from this target group. Primarily obtaining opinions

and liaising with easily accessible individuals rather than attempting to reach hard to engage and hidden populations, apart from on two occasions where outreach work was clearly identified. One post affected within a restructure was the bespoke service user involvement worker in each area no longer existed at the time this thesis was submitted. The commissioning team therefore had to endeavour to ensure the inclusion of service user voices within commissioning decisions despite it not being anyone's designated post anymore. The inference of cutting this designated post being that stakeholder involvement was not seen as a priority within the commissioning team, again denoting tokenism with regards to obtaining the perspectives of service users:

"We've also lost our service user involvement worker as well, and so we're now more reliant on public health colleagues and it's no longer somebody's job – it's no longer their focus – it's just sort of trying to diary it in to their time over the coming year."

ID59, Female, PCT Commissioner, phase 2

Commissioners continued to identify that clinicians had regular opportunities to be involved in consultations; the predominant method for consultations was via the treatment effectiveness groups. This mechanism of involvement provided a monthly opportunity for providers to meet and have face to face contact with commissioners. However, the level of influence providers had been able to have within these meetings was not clear as the treatment effectiveness meetings were primarily used as a forum for contract management and review. Furthermore, the treatment effectiveness meeting only included service managers and not all employed members of staff the quote below describes this well:

"The treatment effectiveness group which is a forum between me and the providers, managers of the provider services in [REDACTED] and the idea really of it is that from a provider's perspective we look at how do we take forward the various actions that we need to do within the year."

ID4, Male PCT Commissioner, phase 1

Further participants explained that treatment effectiveness meetings were just one way to include clinicians in consultations, but alternative methods were also used to

obtain views. A few of the mechanism of engagement available incorporated the voice of clinicians regardless of the position within the treatment agency enabling a more inclusive method of involvement to occur as the following quote implies:

“We have a treatment effectiveness meeting every week and they can air their views there but we also have stakeholder event as well. So we would conduct focus groups, have breakout sessions, we also send out questionnaires and stuff to stakeholders, so it’s sort of you’re not just getting the voice of the manager, you’re getting the voice of the staff also.”

ID2, Female, PCT Commissioner, phase 1

Some participants within the commissioning team went a step further and suggested that on occasions statutory partners had too much influence regarding service provision, suggesting service providers dictated which treatment options they had been willing to provide. Commissioners perceived that they had limited power to decommission or instigate contract changes despite them being responsible for the distribution of resources, as the quote explains:

“Oh! Well our major providers, of course, within this PCT is our own provider arm and they’ve got masses of amount of clout power, even more so probably than commissioning.”

ID7, Male, PCT Commissioner, phase 1

As identified above, participants within the commissioning team provided varied interpretations of the amount and quality of consultations that were undertaken. In an attempt to dismiss or verify the commissioner’s perspective highlighted above, clinicians and service users were also requested to provide an insight into whether they felt they had had opportunities to be consulted within the commissioning process.

During phase 3 of data collection (all 3 commissioners were in a senior position within the commissioning team) the notion of whether participants felt that their voice had been heard provided a consistent response of yes their voices and opinions were influential within commissioning decisions. Statements were made such as *“I think I have a high level of influence on those commissioning decisions because of the role that I sit in”* (ID6, female, Commissioner, phase 3). There was a consistency

in the dialogue that commissioners had, that identified themselves as an 'expert' within regards to the commissioning of alcohol services "*I think probably in terms of the model and moving forward, I had had a fair bit of influence. I've been the expert so to speak*" (ID58, Female, Commissioner, phase 3). However, whilst acknowledging their expert status, there was still recognition that commissioning is a democratic process. The flowing quote emphasises this point:

"I give an expert opinion on it, and feed your experience and your knowledge in around it. But ultimately, it's a consensus view of where people think priorities should go."

ID4, Male, LA Commissioner, phase 3

5.5.2 The Clinician's Voice: Is it being heard?

Within commissioning practice, continuous and meaningful engagement with clinicians was identified as important by the clinicians themselves. However, what became apparent was that clinicians were describing relationship dynamics with commissioners as opposed to their involvement in commissioning decisions. Service providers consistently reported opportunities for open dialogue between themselves and commissioners in a positive manner. There was a perceived implication that being listened to and feeling as though they are heard, was as important as influencing the decisions being made by commissioners, as the following extract demonstrates:

"I feel I can go and say anything I want and they'll listen."

ID17, Male, Service Provider, phase 1

Another participant explained that despite having contractual obligations to fulfil, commissioners could be approached if clinicians felt that an alternative innovative way of working may yield results, as the following quote describes:

"I find them very approachable, the commissioners. If we had any queries, if we had any concerns about our contract delivery, or if we thought is there something we could change, [you know] is there room to put some variation into that? So there's always the opportunity for open dialogue."

ID18, Female, Service Provider, phase 1

The methods of communication and contact were portrayed positively, enabling meaningful engagement to take place between commissioners and clinicians. Service provider participants explained that they felt commissioners acknowledged that clinicians work with local people and had an understanding of the clinical need. The quote below describes this well:

“There’s consultation, in the true sense of the word, which you know I appreciate and I know others do too. I mean there’s a huge amount of experience out there in the providers, and I think what our current commissioners have done is acknowledged that you’ve got that, all that experience to you know call on for consultation.”

ID23, Female, Service Provider, phase 1

When commissioning was at a point of re-tendering and/ or renewing contracts or if new monies had been injected into the alcohol treatment system, then genuine opportunities were felt to exist for clinicians to influence the service design through stakeholder engagement. To provide a solid example of how, as stakeholders, clinicians had been involved in influencing commissioning decisions, participants commented:

“They (commissioners) talked about the £5.6million or something investment that was coming down and ideas were asked for. Services were given the opportunity to talk about how they could further improve on their services but also you have, you know I suppose they have to go through how they decide who gets what through the process of tendering and what have you.”

ID16, Female, Service Provider, phase 1

“Okay, there was that opportunity for services to give their different ideas or views?”

Researcher

“Oh absolutely yeah”

ID16, Female, Service Provider, phase 1

The above participant provided an important example of how engagement with commissioners had led to full engagement and influence over commissioning decisions. However, despite probing in the interviews for more details on participants’ involvement in generic commissioning decisions from a system wide

perspective, service providers focused on their involvement in decisions surrounding their own specific service.

When discussing the opportunity for GPs as clinicians to be involved in the commissioning process, all but one participant felt as if they had avenues available to them to be involved in consultations if they had chosen to via a PBC lead, as the following quote implies:

“Yes because the practice based commissioning cluster leads now sit on the, commissioning executive team meets once a week, so we spend one afternoon a week sitting around the table with the commissioners.”

ID15, Male, General Practitioner, phase 1

There was an understanding that due to rationing, decisions ultimately stopped with commissioners as they were responsible for optimising health gains and the GPs interviewed were happy for the decision making to be the responsibility of commissioners, as identified below:

“I feel I’ve been consulted appropriately. I think that [you know] PCT does have a desire to consult and listen – genuinely. What I can’t influence is their ultimate decisions say on financial matters; and that’s fair enough, that shouldn’t be my decision.”

ID11, Male, General Practitioner, phase 1

A further area of interest explored, was whether GPs felt that their voice had been heard with regards to commissioning decisions. One GP provided an example of a scenario in which commissioning changes had occurred following himself and a colleague approaching commissioners with potential new ideas to improve alcohol services. Although providing an example from 10 years ago, this particular GP stated that:

“Myself and another doctor were unhappy with the local substance misuse service about 10 years ago. We went to the commissioners and said, “We are unhappy.” They actually supported us to research what was happening in our area and eventually develop a parallel service. Our service eventually became the successful bidder.”

ID16, Male, General Practitioner, phase 3

A further GP stated that although he had not had a massive input into recent commissioning changes, he believed that as a GP with a vested interest in alcohol work, he would only need to register an interest with commissioners to become quite influential. The suggestion from GPs was that if individuals had a desire and were motivated to be involved in commissioning their opinions and input would be welcomed. It was stated that:

“You just put your head above the parapets and say, “I’m interested in doing some work, I’d like to be an alcohol lead” for example. They (commissioner) would bite your hand off.”

ID11, Male, General Practitioner, phase 3

Opportunities appeared to exist for individual GPs to be involved in commissioning if they had the desire to do so, although within this small sample the willingness to be involved was inconsistent.

5.5.3 Non participation: choice or oppression- The Service User’s Perspective

Unfortunately, the majority of service user participants stated that they had not been involved in the raft of consultation events surrounding the distribution of the £5.6 million across NHS x as the following two extracts illustrate:

“The money came down in 2007 and as [REDACTED] said at the beginning it was 5.6 million, were any of you involved in consultation events or anything like that when that money actually came down, can any of you remember being asked about anything?” Researcher

“No.” Respondents x 12, phase 1

“Ok, so none of you were actually involved?” Researcher

[Respondents shaking heads]

“Ok, so just to summarise that last bit then, a lot of you feel that in this service there is opportunities to put your point of view across but overall none of you feel like you’ve been involved that much in consultation or shaping services?”

Researcher

[Respondents Nodding]

Of the 12 participants in attendance at the focus group no-one could remember being consulted by the commissioners regarding the allocation of £5.6 million alcohol investment. Additionally, at another focus group the same scenario occurred with only one participant out of 11 recalling an opportunity to be consulted in commissioning decisions. The following quote emphasises this well:

“One of the things I’m interested in as a really brief question is did any of you get consulted, or did anybody get spoken to about how that money should be spent? So I suppose that’s the first question.” Researcher

“No.” Respondents x 10 out of 11 participants, phase 1

“I remember getting invited to a meeting here, where we were discussing what we’d like to be done [yep] with the money and there was a lot of publicity put up about that but not very many people come.”

ID35, Female, Service User, phase 1

When discussing involvement in commissioning decisions with service users, apart from the two examples given above, discussions changed almost instantaneously to focus on an individual’s experience of consultation regarding their *own* care package and not generic stakeholder involvement made on a service level. Despite the majority of service users talking about their treatment experiences rather than stakeholder involvement per se there was a potential connection between the two issues. The experience that individuals had whilst accessing their own treatment package could influence the levels of motivation to be involved in stakeholder involvement at alternative stages in their life journey. If service users felt that they had the power to influence their own individual package of care, this may have led to feeling that attempting to influence anything on a larger scale was futile.

Arnstein’s ladder has a rung representing ‘therapy’ which denotes no power on behalf of stakeholders. The examples provided below reinforce this suggestion by Arnstein that at the therapy level of involvement despite stakeholder having an alternative perspective to offer they have no real influence.

Service users described feelings of disillusionment, as professionals’ technical expertise often seemed to be used as a source of power when liaising with service users, participants explained:

“I felt like the inferior and they were the superior, they were the professionals.”

ID57, Female, Service User, phase 1

The majority of service user participants interviewed emphasised that they were ‘experts by experience’ and their voice should have been accorded a high level of validity when considering service design and delivery. Most participants felt that although workers were classed as the professional, it was the service users who could be considered the experts in alcohol misuse and through their experiences they had a significant insight into the alcohol treatment system. Participants within the focus groups were in agreement that the service user voice should be heard and hold equal value in commissioning and decision making. Despite probing, an alternative view was not expressed however; each individual participant had been motivated to attend the focus group specifically for the reason of expressing their views and having a voice. The following quote makes the point:

“There isn’t a qualification about being an expert, there isn’t. There isn’t a qualification in being an expert; the only expertise you get is doing the damn thing, so if you do it then you’re the expert.”

ID50, Male, Service User, phase 1

The frustration of ‘not being heard’ or opinions being overlooked were verbalised. Participants within the service user focus groups clearly articulated their view as to why commissioning decisions should come from the service user perspective up over, they stated that:

“It does make sense to talk to the people (service users) because they’ll know instinctly from what they’ve been through what good practice is. Because if it’s helped them, clearly that’s something that should be looked at, what was done that helped them and as the receiver of the help I think they’re in a much better position to know what’s needed and the sort of approach that might be taken.”

ID56, Male, Service User, phase 1

Many service user respondents described feelings of disempowerment at certain points within the treatment experiences. In these cases, instead of service users

feeling hopeful due to receiving support, a few individuals identified that they had left treatment services feeling subdued and pessimistic due to the lack of empathy and support they received. For the majority of service user participants, they implied that participation in decision making had not occurred frequently at any level, inclusive of having control over their own treatment. A theme of 'disempowering environments' was an issue described frequently by service users due to the lack of perceived involvement or control in devising their own treatment plan. The point is made in the following quote:

"I just think there needs to be more sort of cohesion, there needs to be more consultation between the services and the service user needs to be more sort of empowered if you like, and say what they need, which direction they need to go."

ID48, Male, Service User, phase 1

The importance of being equally involved in constructing their care package was identified as a priority for service users. The relationship with health professionals was important and some individuals felt that participation for them was being able to discuss their problems with health professionals. However, some participants did not feel that they were listened to even in this capacity as the following quote shows:

"They (clinicians) could have sat and listened, listened, they don't talk to ya they talk at ya, proper get in ya head, things ya don't want to remember they bring it to the front of ya head and then they you, excuse ma language fucks ya, it fucks ya up. And then ya just hit the drugs and drink."

ID52, Female, Service User, phase 1

An important factor to draw attention to was that the majority of participants that attended the focus groups were service veterans, with many having experienced multiple treatment episodes inclusive of alcohol detox's and residential rehabilitation. Therefore, many participants expressed an opinion that voices should be heard regardless of whether the stakeholder was contributing from a service user or a professional perspective. This perspective may not have been as unanimous had service users from a wider spectrum been present at the groups inclusive of individuals receiving one off interventions. However, despite being an open invite it

was predominantly individuals with many years' experience of treatment services that opted to attend the focus groups. Many service users experienced a knowledge imbalance i.e. 'professionals' had the technical expertise, which led to them adopting an authoritative role, as opposed to a mutual role with service users 'See service x try and tell you what do' (ID31, Male, Service user, phase 1). Even at the level of receiving treatment, participants felt as though services dictated to them, emphasising the case that if individuals described not being able to influence their own treatment journey, it was difficult to influence decisions made by commissioners. Furthermore, respondents described feelings of coercion or lack of consideration for their individual wants and needs, value judgements were being made on behalf of the patients. Service user respondents commented that:

"Some people think they get pushed into the rehab or the detox and it's totally wrong."

ID28, Male, Service User, phase 1

Scenarios in which individuals felt that services had not respond as expected resulted in service users not receiving the help and support required to address their alcohol use:

"well I found Service K when I rang them, they were gonna get back to us and they didn't and I rang them again and they still didn't get back to us which I thought was, coz it took a lot of courage to actually pick the phone up and admit you had a problem."

ID32, Female, Service User, phase 1

Other participants reinforced this view conveying a feeling that some professionals could be perceived as being unsympathetic or insensitive which impacted on the treatment experience as the quote below describes:

"What do you call it interchange or Service J, as far as I'm concerned were a dead loss...To me it felt, when I look back at it now, it felt like lip service."

ID36, Male, Service User, phase 1

Despite questions probing about stakeholder involvement in commissioning, the above quotes all relate to service users treatment experiences rather than their involvement in commissioning per se. The consistent theme from the service user perspective even at the level of treatment provision was lack of power and/or influence in their treatment journey. This lack of perceived influence on behalf of the participants that attended the focus groups and the lack of attendance by service users only accessing tier 1 and 2 services was worthy of note. It raised the question of whether these individuals would subject themselves to become involved in stakeholder involvement events if they felt they would not have any influence on decisions made. Furthermore, if only experienced service users attend involvement events the perspectives obtained may not have been representative of all individuals who need to access an alcohol intervention within their lifetime.

5.6 Do stakeholders *want* to be involved in commissioning?

This section presents themes and commonalities that emerged when exploring stakeholders' motivation to be involved within the commissioning process. When considering whether stakeholders wanted to be involved in commissioning decisions, participants showed an awareness that not all stakeholders had prioritised involvement in alcohol commissioning over their core day to day business. The quote below illustrates this well:

“There's no point in expecting the Police to give their time up to come and listen to you talk, unless there's some meaningfulness in it for them. I say the Police; it's not just them, but any other key people. You won't get people out of hospitals, who are busy doing operational things, unless there's something really in it for them.”

ID4, Male, LA Commissioner, Phase 3

There was an acknowledgement that the issue of alcohol is far reaching and many individuals who could be involved in commissioning may not identify themselves as key stakeholders. The following quote makes this point:

“This is one of the challenges I think we’ve faced over the years is that substance misuse it’s almost like a speciality and it’s almost like it touches these wider stakeholders in terms of safeguarding children, safeguarding adults. There are high incidences of it, but it’s not their core business, so I don’t think they probably see they’ve got a role in it.”

ID21, Male, Service Provider, Phase 3

When specifically considering the stakeholders interviewed, by default, commissioners did not discuss their willingness to be involved in commissioning; it was taken for granted that they wanted to be involved as it was their chosen career. However, both GPs and service users did discuss their motivation to be involved in decision making. All GP participants were aware of who the lead GP within their practice was for commissioning and had a level of awareness of how to include their clinical voice if they wanted to become involved in the process. There was limited motivation for some GPs to become involved in commissioning, in the group interviewed 2 out of the 6 GP participants being actively involved in commissioning and the consultation process. GPs’ willingness to be involved in the commissioning process was variable, from individuals volunteering to take up the Practice Based Commissioning lead mantle to a ‘jobbing’ GP on the other hand whose interest to become involved in commissioning was minimal. Participants acknowledged that motivation for GPs to be involved in commissioning varied and resulted in a division between those who did and those who did not want to partake in the commissioning process. The quote below from, a GP heavily involved in commissioning makes the point:

“I probably know more about commissioning than most GPs, because I think a lot of GPs are really quite divorced from it. But I know the commissioners. I think most GPs are, they are aware of practice based commissioning. Its true most GPs aren’t that committed to practice based commissioning, it’s the keen few.”

ID11, Male, General Practitioner, phase 1

Additionally, the GPs interviewed were resigned to the situation that only a few GPs chose to get involved in commissioning, thus leaving the onus on a minority of GPs who have an interest in the subject area or feel obligated to contribute. A feeling of being coerced into becoming a representative for alcohol commissioning was

described, a concern being that if it is the same individuals are continuously contributing then there is potential for stagnation to occur. Those GPs that did not want to be involved were considered to be in the majority, with a few enthusiastic GPs being in the minority as shown below:

“We’ve highlighted a problem that there are very few of us that have been involved in the commissioning process, and so you tend to get the usual culprits being involved in these things. It’s not a cost effective use of our time but some of us have an interest in that sort of thing but, it’s feeling that if we don’t take it on there’s nobody else to do it, so we we’re stuck with it.”

ID15, Male, General Practitioner, phase 1

The majority of GPs had a passive attitude to commissioning and they substantiated their lack of involvement in commissioning by providing justifications regarding the ‘other’ roles they were involved in. One GP participant commented:

“I suppose I’m one of that that sit here and complains rather than does something about it, so I’m not tremendously proactive in terms of that sort of thing. I mean I have great big other chunks of stuff I do and that’s my role, we’re a training practice and I do all that stuff but yeah it’s not my bag and I’m afraid I leave (commissioning) responsibility to other people.”

ID13, Female, General Practitioner, phase 1

Despite participants vocalising their lack of interest and motivation to become involved in the process, all GP participants did recognise the importance of clinician involvement in commissioning. The following quote illustrates this well:

“It’s not an area I’m interested in. I am interested in it up to a certain point – some partners are interested and they will take the lead within that.... It’s not something I’m interested at all – a little bit bureaucratic and it’s not something that excites me. But I think it’s important.”

ID16, Male, General Practitioner, phase 1

GPs acknowledged that GP Fundholding had resulted in some successful outcomes inclusive of reduced waiting times, reductions in prescribing costs, reduction in lengths of stay and delays in transfers of care and an increase in the provision of community services, as discussed in Chapter 1. Nevertheless, despite previous

positive associations with commissioning some individuals were still unreceptive to take part in commissioning activities; the quote below described this well:

“People who liked fund holding were enthusiastic about trying to develop the commissioning process. I think there is a spectrum of views, I think there are people who don’t want any part in the kind of what they would see as management side of it and I think there are people who are very keen to take on a lot of commissioning work. And I think there are people in between and myself I am probably somewhere in the middle.”

ID14, Male, General Practitioner, phase 1

Regarding service user stakeholders, inconsistencies were present between the stated levels of desire to be involved in commissioning and the available evidence showing a lack of involvement in consultation activities. Service users are recognised as ‘reluctant collaborators’ and barriers such as language, lack of confidence and unequally distributed power can lead to service users choosing not to become involved and creating a self-fulfilling prophecy of being a hard to engage group. Service users described attempts at devising and conducting surveys within treatment agencies in an attempt to see what improvements could be made regarding available provision. A participant commented that:

“I think it’s getting people to fill them in isn’t it, I think you’ll probably find a lot of people won’t bother to fill them in, you know they’re just left on the table.”

ID43, Female, Service User, phase 1

Participants within the service user focus groups agreed with this scenario and further involvement opportunities such as suggestion boxes and annual surveys were described as being ‘ignored’ and underutilised. Despite opportunities being available individuals appeared to be uninspired and unmotivated to complete the paper based forms of user involvement as they were identified as being data collection exercises and not genuine attempts to gain the perspectives and opinions of service users.

Notwithstanding the seemingly limited involvement of service users within consultations, participants within focus groups expressed the desire to have more opportunities to be involved in volunteering, attend committee meetings and shape

services. It is worth noting that the participants attending the focus groups showed a level of motivation that may not necessarily be applicable to all service users. However, the majority of participants in attendance agreed with the following comments:

“Personally what I’d like to see is for service users....a regional service user forum, much like you’ve done today but it’s an organised forum and one that meets regularly where the service users themselves can feed directly into the PCT.”

ID34, Male, Service User, phase 1

Some service user participants explained that they felt stigmatised and expressed concerns that due to individuals having an alcohol problem their voice had not been heard or respected. Participants explained:

“It’s getting rid of that huge stigma, whether you’re an abuser, an alcoholic, anything... .. if we get rid of this, shall we say erm goody too shoes people, ... correct arse holes as I call them, get them out the way, bring them down to these organisations and show them what the hell goes on, give them a bit of a shock. A shock in that we’re all human beings, you know we haven’t got 22 heads on our shoulders”.

ID50, Male, Service user, phase 1

A further participant within the service user focus group implied that it was only once an individual was recovering from a substance misuse problem that their opinions were taken into account, as the quote below demonstrates:

“Sometimes you can put complaints in but because you’re an alcohol or drug ...well forget about them, but I’m at the stage where I cannot forget about it and when you get to that stage and you start to question things, and once they know you’re at that stage to start to question things they’ve got to take action because they know ya not just a stupid bugger at the bottom of the heap anymore.”

ID28, Male, Service User, phase 1

The data presented in this chapter have highlighted that from a commissioner perspective opportunities have been available for service users to be involved in

consultations. Yet, despite the majority of participants claiming to want to take part, available opportunities were not always utilised, highlighting that responsibility to become involved in commissioning is both top down and bottom up. This suggests that increasingly creative methods of engagement need to be available if stakeholders' opinions are going to be sought successfully.

5.7 Chapter Summary

The understanding of who constituted a stakeholder and what stakeholder involvement actually was were not consistent among participants. Definitions of who constituted a stakeholder were limited until explored further. Once probed, all participants showed an appreciation regarding the diversity of who a stakeholder could be and there was agreement amongst participants that stakeholders can contribute different perspectives to alcohol commissioning decisions.

When exploring commissioning, the levels of knowledge surrounding commissioning as a concept varied significantly. Only commissioning participants had intricate knowledge of the commissioning process and the impact that changes in commissioning policy had had on decision making. GP participants demonstrated a good awareness of policies and could articulate their involvement and beliefs regarding both historical policies and comment on the future direction of travel regarding commissioning. Furthermore, although service providers and service users alluded to their respective levels of involvement in consultation exercises, they showed little awareness of the multifaceted elements incorporated into the commissioning process.

As identified within the chapter, commissioners described varied interpretations regarding the opportunities available for consultation to occur. There was a discrepancy between those who should be involved and those who actually had the most influence regarding commissioning decisions. Service providers and GPs described the opportunity for open dialogue between themselves and the commissioners, the interactions were viewed in a positive manner. Unfortunately, for many service user respondents, they described a lack of involvement opportunities to influence commissioning decisions.

With respect to 'willingness to be involved', GPs varied from taking on a champion role and leading the commissioning practice forward to 'jobbing' GPs who, whilst recognising the importance of clinician involvement, showed a lack of interest to take part in commissioning activities. The majority of service users stated that they had not been involved in commissioning. However, a contrast occurred as the stated interest of participants to become involved in stakeholder events were described as high whilst the actual uptake of opportunities were limited.

What the chapter has emphasised is that commissioners seemed to view the issue of stakeholder involvement in terms of a broad system-wide process whilst frontline clinicians discussed involvement regarding their own practice/treatment service. Finally, service users discussed their involvement in their own treatment package rather than their involvement in the commissioning process per se. A distinctly different macro-micro perspective was taken regarding all three areas discussed: from the knowledge participants held surrounding commissioning, to the levels of involvement individuals felt they had and their willingness to contribute to commissioning and the decision making process.

Chapter 6 : ‘Doing’ stakeholder involvement: approaches, barriers, and challenges

6.1 Introduction

This chapter initially considers the mechanisms used to facilitate stakeholder involvement in alcohol commissioning, exploring both formal and informal mechanisms of involvement. Second, it identifies barriers to commissioning exploring the impact of monitoring and timeframes upon commissioning practice. Finally, challenges that arise when involving stakeholders in the commissioning process are considered, discussing themes inclusive of feeling undervalued, power, conflicts of interest and competition.

6.2 Mechanisms used to facilitate stakeholder involvement in Alcohol Commissioning

All groups of participants discussed a variety of approaches to facilitating stakeholder involvement common to all stakeholders. When describing opportunities for stakeholder involvement in commissioning and decision-making, participants gave examples varying from ‘top down’ imposed annual satisfaction questionnaires to innovative opportunities for ongoing consultation to take place within individual services. All participant groups made reference to stakeholder involvement in some guise, the main differences were whether the methods of involvement were imposed internally or externally and also at which end of the spectrum opportunities occurred i.e. tokenistic involvement or citizen control as defined by Arnstein’s ladder (1969) as shown in figure 6 in section 3.5. These could be categorised as formal or informal processes.

6.2.1 Formal processes

External methods and formal processes of stakeholder involvement were described as events occurring at a pre-planned time such as a monthly contract review or at a specific point in treatment i.e. entry into or exit from treatment with limited scope for engagement in between. Formal processes for stakeholder involvement are described below.

6.2.1.1 *Annual satisfaction surveys and questionnaires*

Services provided examples of types of stakeholder involvement that they completed to fulfil external requirements. These forms of involvement were generally via centrally imposed documents that were standardised nationally and distributed across all service provider organisations. They were not devised specifically to reflect the local flavour but to collate information for statistical purposes. All services collected information to help construct a national picture of the service user's opinion of treatment agencies. Whether feedback was made available to providers and users regarding the information submitted was not stated therefore the impact of this form of stakeholder involvement was not clear. An example of an annual involvement event is given below:

“What we do is we would have external – questionnaires, surveys - that we would ask clients to, complete on behalf of, say like the NTA and it's generally a yearly one.”

ID18, Female, Service Provider, phase 1

For some services a motive for requesting a service user's opinion was to authenticate a service's existence. An example of this can be seen in the following quote:

“It's done as part of the larger organisation and they will do a six monthly service users surveys which is fed back up the chain if you like, so you know, so that they know we're doing our jobs properly here.”

ID27, Female, Service Provider, phase 1

This form of 'involvement' was focused on assessing an individual's 'satisfaction' regarding services with the purpose of feeding this information back to funders. The majority of external methods were conducted on a one off basis such as entry into/exit from treatment or on a 6 monthly or annual basis. These involvement mechanisms had the potential of not portraying genuine attempts at involvement; rather they identify a one way flow of information with limited scope for individuals to influence service delivery. Furthermore, these mechanisms of involvement only allowed for a snapshot of feedback to be obtained and only capture a small

percentage of individuals in heavy end treatment. The quote below describes this well:

“Within drug and alcohol at this moment in time, we haven’t got a, well we’ve got a complaints and compliments leaflet which goes out, when we offer our first appointment. We evaluate through review and our review form states you know ‘what is the clients ‘thoughts on the situation’ and, the service and everything else’. As far as a single evaluation sheet, we haven’t got one at the moment.”

ID23, Female, Service Provider, phase 1

However, there was also an acknowledgement by the majority of participants that individuals accessing the services could have provided the most insight into the effectiveness of available treatment options. Commissioners identified questionnaires as an appropriate method to collect stakeholder views as highlighted in the quote below:

“We have a really good service user network in terms of we do a lot of questionnaires and I know people get sick of them but it’s about constant improvement and looking for different ways coz if it’s not working they are the people that are gonna know about it.”

ID3, Female, PCT Commissioner, phase 1

When considering the various mechanisms used to facilitate stakeholder involvement, respondents questioned whether the methods of engagement were fit for purpose. The majority of participants within the service user focus groups acknowledged filling in questionnaires ‘at some point’ within their treatment. However, all service user participants agreed that whilst they were the most commonly used method of gaining service users views, questionnaires were the wrong tool to use to elicit information. Questionnaires and surveys were deemed to be too structured, impersonal and did not provide space for individuals to clearly express themselves. Respondents indicated that *“A questionnaire can’t get across the feelings and experiences, you can tick boxes but really, it’s not gonna give any more than that”*(ID56, Male, Service user, phase 1). Service user participants felt as if questionnaires were tailored to find information relevant to treatment agencies instead of being mutually beneficial to reflect the needs of services and individual

service users. Participants within the service user focus groups suggested that current methods of collecting information did not reflect a genuine interest in individuals, views:

“The questionnaires, the questions that they ask ya and the boxes you’ve gotta tick, you probably tick the boxes but it’s not your true feelings, yacannat express yourself in a ticky box situation, its limited to what they want to know not what ye think ya want them to kna.”

ID28, Male, Service user, phase 1

An important element of any consultation event for service users seemed to be for individuals to feel as if their story had been heard and this was perceived to be the main aspect currently missing from the methods of service user participation utilised. Individuals expressed frustration at the limited scope of questionnaires to capture this information, participants stated that:

“You don’t see the people behind the names, you just look at a load of questionnaires filled in by a load of people and there is still stigma attached to that. Whereas if you come here and you see the people face to face and you see that they’re just human beings like everybody else, you know. I think it kind of; it adds a lot more sort of strength to it than just words on a bit of paper.”

ID57, Female, Service User, phase 1

6.2.1.2 Strategic groups and meetings

For service provider stakeholders the discussion surrounding potential avenues for them to be involved in commissioning centred on monthly contract reviews organised by commissioners. However, when service providers were describing this mechanism of involvement it implied a contract review as opposed to a significant opportunity for influential stakeholder involvement to occur:

“Every three months they’ll have a site visit where they’ll literally come in and walk around and look for evidence of what we’ve said we produce and provide or they may want to go and visit a project and see how it’s doing, and speak to service users. Another month they’ll have a themed group where they might say, right for a certain part of your service i.e. harm min, we’re going to focus on that. So there’ll be an interview panel and they’ll ask you questions on your delivery. And then every third month they have a data direct performance review. So that’s when they’re looking at all of our data, NDTMS stats and what have you and obviously the performance of the data.”

ID16, Female, Service Provider, phase 1

The feeling that service providers were consulted in a structured and formal way suggested a level of tokenism and potentially implied a limited scope for partnership working was present.

Commissioners felt that they reinforced the opportunities for ‘professional’ stakeholders to be involved in engagement exercises providing examples of meetings and forums that enabled stakeholders to have a voice, as described below:

“We have a joint commissioning group where all partners sit around, so they would be involved in any commissioning arrangements as well and on there sits the NTA, police, probation, housing, local authority, so it’s a mixture of partners sitting around the table.”

ID2, Female, PCT Commissioner, phase 1

Service users in one of the focus groups described being actively involved in formal committee meetings held within service B *“We have a committee meeting every other month so if anything comes up that wants sorting out it’s sorted out by the committee”* (ID41, Male, Service User, phase 1). Furthermore, when making specific reference to service B, participants stated that a regular pathway for volunteers and service users to express their views was available:

“I would say, given the fact that this is, it’s like the meeting every 2 months with the powers that be (service managers) and we have one today as a matter of fact and that’s another level of getting things passed on to management or whatever, coz what it is basically is that they sit and listen to everybody.”

ID44, Female, Service User, phase 1

The above quote provides an example of when stakeholder involvement extends beyond tokenism; opportunities are available for stakeholders to have a voice if they choose to become involved in engagement opportunities. Again it was hard to assess the actual influence of the meetings as outcomes were not discussed.

6.2.2 Informal processes

Alongside the externally imposed 'formal' mechanisms of involvement, all participants identified opportunities that occurred on an informal basis to capture the stakeholders' voice. Informal processes to involve stakeholders were held more frequently and were described as being pro-active mechanisms. Informal processes included direct consultation, open forums/focus groups, via a key worker and user-led innovation.

6.2.2.1 Direct consultation

With regards to service users as stakeholders, innovative methods of engagement were identified with participants commenting that:

"I think it's very important to listen to the client, you know they've got the answers so we've just introduced part of our new recruitment strategy is we have a client or couple of clients showing the candidates round giving you know the tour of the place and informing them how things run in here and then we sit at the end of the interviews with the clients and take feed-back from them and what they thought about the candidates."

ID27, Female, Service Provider, phase 1

As identified above opportunities existed for direct consultation with service users to take place within agencies. There was a stated intention and wish to engage service user stakeholders on behalf of ID27.

For the majority of services when stakeholder involvement took place at an individual service level, most service providers identified consultations had taken place on a more continuous basis rather than the more standard annual attempts to obtain stakeholder involvement. The following extract illustrates this well:

“We are really adaptable and will look to meet the needs of the client as best we can listen to them you know each day they have to fill in a significant event sheet and it’s part of the treatment.... what also comes out is what they like and what they didn’t like and we read that on a daily basis”

ID26, Female, Service Provider, phase 1

The examples above presented by service providers suggested that involvement took place at a partnership level, with services being responsive to the feedback they receive from service users. Explicit examples were discussed as to how feedback was collected inclusive of service user feedback forms, suggestion boxes, evaluation sheets and patient stories. A number of services described ensuring multiple options for involvement are available *“there’s various ways and methods that people can communicate which will make them feel most comfortable”* (ID16, Female, Service Provider, Phase 1). The increased accessibility to various methods made it more likely to find a format appropriate for each individual. Available methods of stakeholder involvement had enabled service users to protect their identity if they chose to and complete an anonymous proposal or proposition to service development via a suggestion box. Alternatively a forum for open dialogue to occur had been available through weekly community meetings or face to face consultations with managers. In reality for most services the level of impact that these interventions had upon commissioning decisions was hard to gauge, as whilst it was apparent that many opportunities existed to enable service users to be consulted, participants did not explicitly state how much influence the involvement methods actually had on outcomes.

In contradiction to the above inclusive approach to obtaining service user views, two agencies stated that service user consultation had been carried out ‘ad hoc’. For the two agencies below, consultation had occurred in a reactive way rather than being present as a continuous element of (or genuine commitment to) service design and development. However, whilst the engagement of service user was not occurring on a regular basis this particular example could be perceived as being responsive. There is an implication that there was flexibility within the service to instigate change on the basis of an individual comment. As the following extract demonstrates:

“It hasn’t happened very much other than the anecdotal stuff where a client might come in and say well that so and so is great or that’s crap you need to do something about that and then the organisation will respond you know in an anecdotal way a very ad hoc way.”

ID22, Male, Service Provider, phase 1

One participant explicitly stated that the introduction of monetary incentives had helped to encourage service user involvement to take place. However the use of an incentive to conduct service user involvement implies a lack of genuine desire to consult, as represented in the quote below:

“Probably over the last few years it’s been fairly ad hoc in terms of service user’s satisfaction questionnaires. It’s now in the contract, which is really good. That way there’s an expectation that we’ll do it.”

ID21, Male, Service Provider, phase 1

6.2.2.2 Open forums/ Focus groups

Commissioning participants described conferences and focus groups as tools to involve a wide range of stakeholders in decision making. The quote below shows this:

“There was a conference organised by the PCT, which invited the appropriate stakeholders along and our service user involvement officer sort of did the focus group side of that.”

ID3, Female, PCT Commissioner, phase 1

The following quote shows that consultation with stakeholders could be influential in determining the current model that had been imposed regarding alcohol service provision:

“When we’ve presented on the models to the providers and potential new providers or people who are interested, we did three different options. Then they did workshops with them to look at the pros and cons of each option. Then they voted at the end for which model they preferred. The model that they voted for has gone forth.”

ID58, Female, Commissioner, Phase 3

Engagement with commissioners via focus groups and open forums was one mechanism of involvement discussed. However this was not an option that many of the service users had experienced therefore limited discussion took place. When direct contact with commissioners was explored, potential barriers to effective communication between users and professionals were reported. The minority of service users who had been involved in engagement events with commissioners and other stakeholders described experiencing the use of professional jargon within consultation creating a power imbalance between the different audiences. The lack of skilful facilitation ensuring equal 'talk time' between service users and 'professionals' was portrayed by a few service users, with one participant stating that:

"I've been to a few consultations which were supposed to be for service users but, there was staff present from other organisations and I just found that the staff tend to monopolise it, nobody really takes any notice of what service users have to say."

ID35, Female, Service User, phase 1

Only one participant out of the 31 present across the focus groups could recall being involved in consultations directly with alcohol commissioners.

6.2.2.3 *Key worker*

Although not directly acknowledged as a method of service user involvement, a number of participants described talking to their key worker regarding possible changes in personal treatment and general issues regarding the service provision. When individuals had a positive working relationship with a key worker, they described feeling that they could utilise their key worker to get their opinions heard. They also expressed faith that this information would be passed through the hierarchy as required:

“I’ll summarise this you’re talking to your key workers on a 1-2-1 basis or other members of staff and it does get passed back down the chain of command back down to the decision makers. Well we know ■ does take things back to the manager of the team and she comes back with positives or negatives, whichever can be done, how the solution or the problem can be solved so we do know it does go on, it happens so that does give you a bit of faith in the system.”

ID50, Male, Service User, phase 1

Participants felt that individual clinicians or practitioners could provide one accessible method of getting their opinions heard and they reported receiving feedback in response to requests they had made reinforcing that this is a legitimate method of involvement.

6.2.2.4 *User-led innovation*

In two instances examples of a progression from service user to service manager were described. These specific scenarios identified working examples in which current managers had identified gaps in their own treatment journey when they were a service user. These examples reinforced that it is possible for individuals regardless of their status to influence commissioners if they are willing and able to be innovative and to invest their own time, effort and energy to develop a service and fill the identified gap. With regards to these specific instances of service development, service design had progressed until it constituted a legitimate element of the commissioned treatment system. The following quote makes this point:

“The services was actually born from a group of individuals in recovery from alcohol and drug addiction and they identified there was a gap in this style of treatment so they met on a voluntary basis over a two year period you know looking at a model in which they could work... so it’s actually come from the service level upwards.”

ID26, Female, Service Provider, phase 1

One participant clearly stated their own levels of commitment to service development as they described self-funding a project for 18 months before it was acknowledged as a commissionable option. This participant acknowledged that their services had developed from the ‘grassroots’ upwards, they commented that:

“Service B was, registered as a charity in 2005, it started some, what eighteen months before that as, a support group in my home, and for two and a half years I funded it totally out of my incapacity benefit, yeah, yeah. That’s how it started”

ID17, Male, Service Provider, phase 1

The examples provided within 6.1 reflect a complex and variegated set of responses regarding both the opportunities for and the impact of stakeholder involvement within the decision making process.

6.3 Ladder of engagement

Arnstein’s ladder was used to explore where participants perceived, stakeholder involvement to be and where participants perceive that it *should* be. The diagram of Arnstein’s ladder as shown in figure 6, section 3.5 was presented to participants as a visual prompt within the phase 3 interviews.

Commissioners interviewed at this stage, placed levels of stakeholder involvement at the ‘partnership’ rung. It was stated that *“we should be aspiring to be as high up that ladder as possible”* (ID4, Male, LA Commissioner, Phase 3). There was acknowledgement on behalf of commissioners that there was potential for the levels of involvement to decrease if not proactively pursued. The quote below captures this well:

“I would say six, because I do think we have a lot of genuine partnership; but I would say it’s not six moving towards seven, it has the potential to be six moving towards five.”

ID6, Female, LA Commissioner, Phase 3

The practitioners (GPs and service providers) described a much more variable perspective when considering the current position of stakeholder involvement. Despite the introduction of the Personal Health Budget (PHB) which represent a higher form of engagement (specifically aiming for the top two rungs of Arnstein’s ladder- delegated power and citizen control), one participant believed that due to the monitoring culture regarding alcohol commissioning, involvement was unlikely to ever progress higher than ‘partnership’, as the following quote highlights:

“I’m surprised to be saying ‘partnership’ actually. I don’t think it’s an area that maybe we could have more delegated power. But I can’t see the culture of data and management and performance changing.”

ID16, Male, General Practitioner, phase 3

Other participants identified that the levels of stakeholder involvement had been variable in previous years; however the current position was described as falling into the degrees of tokenism category, as seen below:

“I would say that it's more of a consultation, there are more degrees of tokenism and again it's fluctuated over the years. I would like to see that there is delegated power to the stakeholders involving all stakeholders”.

ID21, male, Service Provider, phase 3

This particular belief was also articulated by ID27 whom felt that despite involvement reaching the partnership rung on occasions, it predominantly sat at a tokenistic level:

“I would say it sits between degrees of tokenism and it possibly occasionally heads up to partnership. I would say we’re definitely on - yes, we do the consultation thing, but it’s tokenism I feel. Well, I would fluctuate between a four and a six. I think it should sit at a seven.”

ID27, Female, Service Provider, phase 3

All participants articulated that the levels of stakeholder involvement in alcohol commissioning should sit at the rungs of either partnership or delegated power; however views varied as to where it actually sat. There was recognition that involvement could fluctuate between rung 4 (consultation) and rung 6 (partnership). The variability in perspectives as to where the level of stakeholder involvement sat was worthy of note and an aspiration for involvement to be better seemed to be present amongst commissioner, GP and service provider participants.

6.4 Barriers to stakeholder involvement in commissioning

Participants discussed several barriers within the commissioning process itself which were perceived to detract from, or negate altogether, involving stakeholders in the commissioning process. The two main barriers discussed were the monitoring expectations associated with the current commissioning policy and unrealistic timeframes. They are discussed in more detail below.

6.4.1 Monitoring

Participants described national policy as dominating commissioning within the NHS and social care. A clear appreciation of the NHS's ability to collect and manage data was present. The majority of participants reported that the monitoring tools that were available for alcohol only focused on activity and not on outcomes:

“The NHS historically, traditionally and classically is brilliant at providing lots of activity and providing lots of systems and processes that allow you to quantify we did so much of this, this quickly.”

ID8, Male, PCT Commissioner, phase 1

In a positive sense, participants stated that monitoring provided a clear direction of travel and served to keep an issue on the political agenda. It was acknowledged by all commissioning participants, that when targets were not available regarding a public health concern such as alcohol, commissioners lost momentum and it was harder to keep partners focused. Topics of concern were more likely to descend down the political agenda, falling behind the subjects that are monitored tightly and have transparent levels of accountability. Therefore, when monitoring did not take place commissioners stated that alcohol was not given enough attention, the implication being that monitoring actually provides the focus that commissioner's desire:

“The alcohol agenda from a local point of view has maybe slipped off the radar a bit because it's not that where, say, for the drugs perspective, reporting into the national treatment agency and we've got that monitoring and then going through the Safer Communities Group within Gateshead whereas probably it's a bit... we need to put it all together again, I think. We've lost some of the focus maybe.”

ID58, Female, PCT Commissioner, phase 2

Participants felt that at a local level, commissioning had lost momentum regarding alcohol due to other public health issues taking priority and being monitored closely both within the previous PCTs and the current local authorities. Time was focused on meeting targets in other areas to the detriment of alcohol services. Commissioners explained that their time and focus had been split between a large remit inclusive of

substance misuse, obesity, smoking, sexual health and a number of other public health priorities. The majority of the commissioning participants stated that the monitoring of alcohol interventions was minimal and explained that this perceived lack of political interest in alcohol had been detrimental to keeping it in the spotlight with regards to focusing commissioning activity. However, participants portrayed an inconsistent belief regarding the value placed on monitoring. On one hand commissioners verbalised their frustration at not being monitored which indicated that alcohol was not being deemed a priority but on the other hand when discussing the monitoring that had taken place regarding alcohol it was not always portrayed in a positive sense. For instance, commissioners felt that the results produced from the national drivers were irrelevant in real terms to the successful outcome of a treatment intervention “*We can understand that we’ve delivered this many sessions but we can’t understand what the impact is*” (ID7, Male, PCT Commissioner, phase 1). There was consensus that there should be a move towards outcome monitoring rather than proxy indicators. Participants stated that monitoring should:

“Be much more focused on achieving the outcomes, so whatever outcomes are going to be important to the individual to attain sobriety, stability, abstinence and basically a pattern of life that allows them to move away from the substance misuse.”

ID8, Male, PCT Commissioner, phase 1

Current targets were described as highly prescriptive resulting in a reduction of the autonomy for commissioners to invest in services that complement the ‘local flavour’. By default if central government state that services need to be commissioned a certain way then the scope to adapt according to stakeholder involvement is automatically going to be limited. Areas for investment locally were prioritised dependent on drivers imposed nationally therefore limiting the real impact that stakeholder involvement could have on local service provision. Furthermore, the monitoring of alcohol interventions was perceived to be unbalanced in comparison to drug targets and it was stated that meeting drugs targets took precedence over alcohol targets. Regarding alcohol, there was a clear acknowledgment that only one target had been focused on and that was the reduction in hospital admissions. Participants described that due to only having one specific target to meet, alcohol

lacked focus in other areas. An implication being that stakeholder involvement was only likely to be undertaken in areas of specific interest or concern for commissioners (which could be imposed by national government structures), limiting the scope for involvement surrounding other areas of alcohol treatment:

“I guess the only performance figure that matters, if you like, for alcohol is the reduction of hospital admissions.”

ID7, Male, PCT Commissioner, phase 1

The perspective expressed by many participants showed that they had resigned themselves to targets *“Of course it’s a no-brainer. National drivers, you tackle those first, they’re the priorities that prove to work and you just do it”* (ID5, Male, PCT Commissioner, phase 1). This style of working had the potential to result in the disempowerment of employees as their levels of autonomy were diminished. Furthermore, the presence of top down monitoring had the potential to stifle innovation; there was no need for stakeholder involvement as priorities are already identified as predefined through national drivers and monitoring. The understanding being portrayed by participants was that the prioritised target took precedent within their daily work:

“Whether they be locally, regionally or nationally determined targets, so by hook or by crook they basically pay the bills, we’ve got to actually meet those targets.”

ID8, Male, PCT Commissioner, phase 1

This was intensified further as the level of scrutiny surrounding alcohol service provision was minimal and all participants described attending strategy groups to present alcohol information however, a certain level of analysis appeared to be lacking. The quote below implies an implicit desire to be monitored in order for their work to be recognised and valued:

“I can see when the drugs treatment plans are presented and the drugs finance plans are presented, you know you’ve got the NTA there you’ve got partners who are going through it and asking a lot of questions whereas with alcohol when I take alcohol its more for information. You know there’s not that kind of scrutiny of people going through it with a fine tooth comb.”

ID1, Female, PCT Commissioner, phase 1

Service provider participants acknowledged that monitoring had been an important mechanism used by commissioners to examine the productivity levels within services however opinions differed as to the purpose of statistics. Clinicians believed that the current targets were the wrong benchmark to use and outcome based monitoring was identified as being more appropriate, as illustrated by the following quote:

“Numbers don’t mean quality of service. They don’t you know. It’s a wrong benchmark to use, if we’re using people as targets, you know, treatments targets, tick boxes, well, That doesn’t always say we’re doing the best we can, that we’re getting the outcomes we want.”

ID15, Male, Service Provider, phase 1

A feeling of frustration was articulated on behalf of many service providers in response to the current methods of performance management, the implication being that statistics could be manipulated as the following quote demonstrates:

“My feeling in this field or business now is that there is just too much on statistics, outcomes, outputs and they’re just words. We can all give good outcomes. I could tell you that 96% of my detox clients’ leave here having completed treatment. That would be true; however what I wouldn’t be saying was that is just the start of the journey for some people. So within days they could lapse. You know what I mean? So to me, statistics they can be slanted any way you want to hear them.”

ID27, Female, Service Provider, phase 3

Despite the belief being that statistics did not accurately reflect the work conducted within treatment agencies, some services believed that monitoring was a necessity to justify their existence. Services confirmed that they could see the value in monitoring *“It’s important you know it is important to be able to say actually yeah this level of investment, achieved that amount of output”* (ID19, Male, Service Provider, Interview, phase 1). In reality participants were requesting more monitoring to try and raise the profile of alcohol:

“I think the National Treatment Agency should, and the government, should actually take responsibility and say right we’re going to treat alcohol misuse and treatment the same way as we’ve done drugs; we’re going to prioritise it..... we need to be monitored, and that’s a provider saying that because the thing is it’s almost like a big stick if you give us a big stick and tell us you must do that we will do it.”

ID18, Male, Service Provider, phase 1

Monitoring was also an area creating discussion for GPs. Participants acknowledged that the increased use of Screening and Brief Interventions (SBI) had impacted upon their work. All GP participants made references to the fact that SBI had been rolled out and were being utilised within their practice. However, regarding the monitoring of these interventions a contradiction arose between what participants described as a simplistic ‘quick and easy’ assessment tool and the associated time barrier attached to conducting the intervention. Furthermore, there was a time constraint attached to monitoring the outcome of the SBI intervention. Despite being a commissioned aspect of the alcohol treatment system most GP participants commented that in relation to SBI they did not formally complete paperwork or monitor the ‘scores’ from the interventions:

“I don’t tend to use the formal scoring system rather than just, you can see where the patient is at any point and it’s I think we probably should document scores and things like that but I don’t like filling in little ticky boxy questionnaires and things like that, I’d rather spend time talking to them and I find it works quite well.”

ID13, Male, General Practitioner, phase 1

Participants had an awareness of what was expected from them regarding the reporting of statistics, yet all GP interviewees acknowledged that monitoring exercises were not always completed as required, one quote demonstrating this is:

“There’s a dissonance between what people say and what they do. It’s not very often I... occasionally I use the audit tool....and occasionally I do direct people for advice and I log that on the computer, but to be honest, not very often.”

ID14, Male, General Practitioner, phase 1

Despite acknowledgement from GPs that they did not always complete monitoring as required, there was an acceptance on behalf of many participants that “*all the commissioners are currently concerned about is what is your performance at the end of successful completions?*” (ID16, Male, General Practitioner, phase 3). The perception amongst GP participants appeared to be that commissioners placed more emphasis on the monitoring and reporting of statistics rather than on the actual activity per se (inclusive of monitoring the quality of interventions delivered).

The methods of monitoring which currently informed commissioning decisions were viewed as potentially inaccurate and they only reflect outcomes important to alcohol services rather than individual service users. Service users questioned the permanence of some of the statistics collected, due to them only capturing a snapshot of a service user’s treatment journey:

“Sometimes I worry when so many people use statistics like certain organisation say we’ve helped so many percentage of people to do this that and the other but they don’t actually follow you up afterwards, like they don’t look along a year later, I bet ya anything like a lot of people will have slipped back.”

ID30, Female, Service User, Focus Group, phase 1

6.4.2 Unrealistic timeframes or a lack of proactive planning?

The notion of unrealistic timeframes created discussions specifically in relation to the distribution of the substantial £5.6 million alcohol investment given to NHS [REDACTED]. The limited timeframe between initially receiving the £5.6 million and having to spend that investment was described as a hugely influential factor on how services were commissioned and how stakeholder involvement did not occur as hoped, due to the speed with which money had to be distributed and decision made. All but one participant within the commissioning team agreed that there was pressure to spend the money quickly “*The timescales obviously could have been improved to give us more time to think*” (ID6, Female, PCT Commissioner, phase 1). All participants expressed concerns around ‘realistic time frames’ or more accurately the lack of them. The tight timeframe was viewed as debilitating and participants stated that if the timeframe had been more realistic, a bigger impact could have been made on the overall outcome of the alcohol services commissioned:

“I mean one of the...the unhelpful pressures was to comply with the business plan and deliver it in a time constraint that was barely legal or ethical in my view. That was a massive handicap in so much as it took away a lot of the initiative to stimulate the market properly so we’ve ended up really, it’s almost like taking a photograph and a snapshot of how something is and we understood that but there was probably more work could have been done to maximise the impact of the investment and so we just went with what we knew and understood at that point. My personal take on that would be if more time had been taken in the planning and development side of it rather than looking just to find the...the legal and democratic trigger to release the money then we would have had, even though it could have taken a bit longer, it would have actually had a better impact overall”

ID8, Male, PCT Commissioner, phase 1

However, there was a resignation on behalf of participants that the limited timeframes were a cultural trait of the PCT *“I don’t think that was the fault of anyone in this team, I thinks it’s just the way the PCT operates”* (ID1, Female, PCT Commissioner, phase 1). Participants felt that the limited timeframes had been detrimental to the way that commissioning had been undertaken. When asked to consider the available timescales in hindsight at phase 2 of data collection (2 years after the initial investment); participants still deemed them inappropriate with the following statements being made between two participants in a focus group:

“We didn’t have the luxury of that timescale, did we? Because the pressure was on to spend the money, so...”

ID58, Female, PCT Commissioner, phase 2

“I think that’s cost the NHS because I’m just coming to this subject area and in terms of the changes in the NHS I think a lot of services have been reactive, and as you say, added on to. And it’s about –it’s very much about the pressure has been on to spend the money and to expand services, whereas I suppose in this financial climate now we’re actually looking at what we’re spending, our money – how can we get value for money and how can we get more for our money and that is a complete contrast.”

ID59, Female, PCT Commissioner, phase 2

Participants felt that short timescales had not been conducive to conducting a systematic need assessment relating to alcohol services. It was stated that if more time had been available the impact of available resources would have been maximised further:

“We do the job but I would like to think that I do it to the best of my ability but because you’re compounded by timeframes and you’re firefighting almost all the time. You must do this, you must, everything is reactive. You don’t get the luxury of being proactive sometimes. Whereas I think sometimes to have the luxury of time and being proactive you will see better gains but because you have to satisfy the beast, because you have to fill this form in, or you have to you know comply with targets and inputting data you don’t get that luxury anymore.”

ID3, Female, PCT Commissioners, phase 2

A resounding agreement between participants when reflecting on the commissioning process was portrayed as follows *“if you want to do it properly and avoid waste you may as well do it a bit slower and make sure you’ve got it right”* (ID6, Female, PCT Commissioner, phase 2). The above quotes highlighted that the commissioning team did not appear to have an ongoing needs assessment and planning process, they responded in a reactive way when new investment occurred or services had to be re-commissioned.

6.5 Challenges of involving stakeholders in commissioning decisions

Themes around the challenges of involving stakeholders in the commissioning process emerged throughout the analysis and they are discussed in more depth below.

6.5.1 Feeling undervalued:

Monitoring has been discussed previously, however, a theme of stakeholders describing being undervalued emerged and monitoring is a prime example of this. Monitoring was raised by service users who described feeling as though the way services were monitored resulted in individuals feeling as though they were ‘just a number’. Participants stated that it felt as though some agencies just ticked boxes to measure their productivity rather than focusing on meaningful outcome measurements for service users:

“As I say, you go to some agencies and I said this earlier on, you’re a name, rank and number and that’s as far as they’re concerned you know once you’re out the door, that’s it. So let’s get the next one in so the conveyor belt is up and running and it’s a numbers game and that’s what I’d put it down to.”

ID50, Male, Service User, phase 1

The formal monitoring element of commissioning practice resulted in some service user participants describing that at times within their treatment they had experienced an impersonal service, commenting that *“services I’ve accessed in the past, don’t actually see you as a person, you’re a case, you’re a name”* (ID57, Female, Service User, phase 1). Furthermore, these participants worried that the information they provided could be manipulated and information would be disregarded if it did not fit with what agencies were looking for. Rather than being conducted in terms of ‘adding richness’ to the process, these service users felt that on a national scale it was carried out purely because it was contractual and this led them to feel; less likely to participate in stakeholder events. A challenge for commissioners when involving stakeholders inclusive of service user and members of the public, is that participants need to feel valued and that their opinion is being genuinely heard, accurately conveyed and also actually used to influence decision making. As the following quote identifies:

“You’re gonna be thinking well who’s actually gonna see this questionnaire that’s filled in, who does it go to, who’s gonna see what I’ve put or is somebody gonna say well that’s about such and such, that’s not going in. Who does it eventually end up with; does it go through a load of people reading through it first?”

ID61, Female, Service User, phase 1

The potential for this method of questionnaires to influence service design was doubted by most service user respondents with the belief that some professionals adopt a ‘tick box’ attitude. This detracted from the primary purpose of service user involvement; that of developing services in accordance with needs identified by the community. This was seen as running the danger of creating a self-fulfilling prophecy, that of individuals believing there is no point in engaging in consultations as their suggestions would go ‘unheard’.

However, the sense of being undervalued was also present within the commissioners who described attending meetings and presenting alcohol data whilst not being certain what actually happened to the information once it had been disseminated at partnership meetings such as Drug and Alcohol Strategy Group and

the Crime and Disorder Reduction Partnership. The influence these meetings had regarding alcohol commissioning decisions was often unclear, as the quote below illustrates:

“We do now have the drug and alcohol strategy group which is a newer development and that feeds in to the Crime and Disorder Reduction Partnership. It’s one of the thematic groups so that’s another line of accountability so, for example, our drugs needs assessment has just gone to the CDRP, our drugs treatment plan will go there and I would presume that the alcohol plan will go there but it’s almost...I’m not certain that we can say it goes there for anything other than information.”

ID6, Female, PCT Commissioner, phase 1

There was a resignation, at least in some commissioners, that in certain environments their opinions did not hold much value and there was limited scope for open discussion to occur or decisions to be influenced by the stakeholder input.

6.5.2 A power imbalance between Commissioners and Providers

Through analysis of the data, themes emerged around challenges that arose when trying to encourage input from stakeholders. Commissioners made specific reference to challenging relationships with statutory service providers and General Practitioners. Despite the commissioners and the statutory alcohol services both sitting under the PCT umbrella at the time of Phase 1 interviews (2010), commissioners described the PCT statutory service providers as a powerful organisation to contend with. Far from being an open and mutually beneficial relationship, when discussing stakeholder involvement with the PCT statutory services, commissioning participants explained that these services required incentives to engage with commissioners and to fulfil their contractual obligations. Information was rarely traded informally and if commissioners request information it has to pass through ‘official channels’ before being shared, the quote below describes this well:

“Everything kinda has to go through official channels and almost be vetted beforehand to see if what your asking could be towards their detriment and then if it is, then generally you get the whole fight of the PCT provider arm coming down upon you. It’s very much like is this in the contract, if not we won’t do it, you know, unless you’re giving us large sums of extra money in which case oh yes we’ll do it then. Yeah and the feeling that you get is that they see themselves as almost being untouchable.”

ID1, Female, PCT Commissioners, phase 1

Rather than commissioners and PCT statutory service stakeholders being viewed as 'equal' partners, commissioning participants portrayed an image of a power struggle with statutory services when attempting to enforce that they fulfil their contracted responsibilities, as the following quote implies; "*within this PCT is our own provider arm and they've got masses amount of clout, even more so probably than commissioning*" (ID7, Male, PCT Commissioner, phase 1). This quote emphasises that all stakeholders have the capacity to feel undervalued. It is assumed by most people that commissioners are in a position of great leverage due to them holding the 'purse strings' however, data emerged to oppose that status quo. Furthermore, it wasn't just statutory treatment providers that created challenges for commissioners. GPs were also identified as problematic stakeholders to connect with, being described as 'hard to engage' from a commissioning perspective even though they were often the first point of contact for service users and a pivotal part of the alcohol treatment system. All of the commissioners interviewed, recognized that GPs are an important set of stakeholders given their position as frontline clinicians working within substance misuse. The work that GPs were undertaking appeared to be an unknown quantity for commissioners and it was acknowledged that work needs to be undertaken surrounding knowledge that GPs have regarding alcohol service providers and appropriate referrals. Commissioning participants stated:

"There is a lot of work there to be done with GP's in terms of their awareness of services and what services, at what point an individual requires a specific service and not just all referring them to detox..... to be perfectly honest we need to get a picture as commissioners of what is actually happening within GP services around alcohol, coz I bet its massive."

ID3, Female, PCT Commissioner, phase 1

Furthermore, whilst discussing service providers stakeholders, commissioners highlighted the challenge of stakeholders having inflexible views of what needs to change in the alcohol treatment design. The following quote makes this point:

“You may also find you'll have stakeholders who are also locked in their own way of thinking, and won't accept the need to change anything, which is the particular challenge at the moment”

ID4, Male, LA Commissioner, phase 3

6.5.3 Conflict of interest

A couple of examples emerged in relation to conflicts of interest. One of the main concerns was regarding the management of stakeholders with multiple roles or identities with the commissioning process and a further concern was expressed in relation to balancing the requests for change made by stakeholders and the discontent expressed by those (often similar) stakeholders when constant change is occurring. The potential for a conflict of interest to arise was a challenge regarding clinician stakeholders who were also service providers and/or GPs. This was a complicated issue to consider as the following quote implies:

“Engagement of clinicians, again that's something we're keen to make sure was you know brought into the alcohol stuff, it's a difficult one that because you have to balance the fact that the clinicians are also the people that you'll be contracting with.”

ID4, Male, PCT Commissioner, phase 1

The potential for a conflict of interest to occur was explicitly acknowledged by commissioners and GPs. GPs stated that due to their dual role of stakeholder and clinician, there was potential for their voices to be excluded. Their concern was that the effectiveness of decision making had been diminished without the input of frontline clinicians, this interviewee explained:

“My Clinical Lead voice has been excluded but then I mean I understood you know why there had to be this you know because I am a provider as well you know that they, I couldn't have a commissioning role well that's fine I didn't want a commissioning role but they had to make sound base on, sound clinical, you know this, the, the decision making had to be based on sound clinical theory and it, and it wasn't.”

ID12, Male, General Practitioner, phase 1

In addition, a further GP articulated the predicament commissioners may face when involving stakeholders in consultations. The ability of commissioners to establish the motivation for clinicians' involvement in commissioning and the skills to negate any potential conflict of interest was paramount. The quote below describes this well:

"I think a GP perspective is always useful. I suppose it's difficult to decide whether it's somebody who's has a particular alcohol axe to grind or an average GP would be more useful, I suppose you get bias with both."

ID14, Male, General Practitioner, phase 1

From a slightly different perspective, commissioners discussed the conflict of interests that occur for service providers. Service providers present information to commissioners which ultimately resulted in contractual changes being made. Therefore, it is inadvertently the service providers themselves that contributed to the continual modification of the treatment system. The quote below highlights this:

"We're accountable for spending the money right so it has to be challenged by people and in a sense by the nature of the game it means that the change process is permanently there. They, in a sense they drive it.....to some extent they may not realise that they're doing it but y'know a large proportion of our intentions over the next year are based on what providers come back to you and say 'well this doesn't work'; 'that pathway's not right'; 'why don't you change that?' They don't necessarily realise that in order to change it puts us in a world where we have to do something quite drastic."

ID4, Male, PCT Commissioner, phase 1

Commissioning participants suggested that a concern regarding alcohol service stakeholders providing information which could result in almost continual contractual renegotiations was that these stakeholders may stop contributing to the commissioning process. If these stakeholders perceived that their input into consultations and engagement events could potentially lead to their service being decommissioned they may choose to withhold their voice in an attempt to protect their own interests. This has the potential to result in a system that languishes due to limited clinical input from frontline clinicians.

6.5.4 Competition between providers: A sense of rivalry and lack of collaborative working

The sense of rivalry and lack of collaborative working between service providers was a challenge for commissioners to manage. Commissioners described witnessing agencies feeling as though they were in direct competition with other services and that they had to 'battle' over resources and the tendering process enhanced this feeling of rivalry. Due to the competitive aspect involved in the commissioning of alcohol services, it was stated that:

"They'll compete in tenders against each other you know you get yourself in positions sometimes trying to integrate services and they'll almost say well it's not in my interest to communicate that well with other services if we think that there's a threat of tender coming, because for want of a better word, they might nick our ideas."

ID4, Male, PCT Commissioner, phase 1

Commissioners expressed that in some situations providers often wanted to protect their own interests, which could lead to limited sharing of ideas and good practice. When stakeholders were unwilling to share ideas openly it led to stagnation within the treatment system. Within the commissioning role competition is claimed to stimulate the market, however, when making direct reference to the alcohol treatment system the tendering process was described as destabilising the market and eroding partnership working. Commissioning participants saw this as damaging to the individuals and alcohol treatment as a system, a quote highlighting this is:

"If you look at a treatment system we're really struggle to engage them in that. They, you know, have actually said we are not sharing information with other providers, we're not going to share good practice because that, you know, they could be our competitors in the future and that just starts to become really damaging actually to the treatment system."

ID6, Female, PCT Commissioner, phase 2

There was acknowledgement that commissioners faced a challenge of trying to diffuse the competition between service providers as one commissioner outlined *"feedback that we've been getting is about the lack of care-coordination and in many ways what we're hearing is that services don't trust each other"* (ID1, Female, PCT

Commissioner, phase 1). This lack of trust between agencies was viewed as counterproductive and the sheer quantity of potential 'partners' across the alcohol treatment spectrum enhances the probability of competition occurring. When service providers specifically described partner treatment agencies, some participants described agencies having an 'us and them' approach. There appeared to be some uncertainty about working closely with treatment providers who were perceived to be in 'direct competition':

"There are lots of areas that could be improved with a bit more partnership working, where agencies weren't so cautious about other agencies getting involved and working together there wasn't so much this; this us and them type approach."

ID22, Male, Service Provider, phase 1

The lack of collaboration between specialist alcohol services was continually identified as an issue within the commissioned alcohol treatment system. One specific example causing frustration was dual diagnosis and the lack of recognition as to whose responsibility it was to address this problem (particularly around addiction and psychiatry care). A lack of policy and guidance appeared to enable the confusion to continue occurring, with neither psychiatry nor addiction practitioners taking a leading role to address the co-morbid issue. For clinicians faced with trying to provide a professional service the lack of distinction regarding whose responsibility it was to care-coordinate these complex service users was exasperating. Likewise for dual diagnosis service users, the lack of clarity when attempting to address their problems was obstructive to their recovery. The example of dual diagnosis was seen as representative of stagnation within the alcohol system. Multiple stakeholders inclusive of commissioners have identified it as a problem within the system however, participants portrayed that nothing has changed in years.

Dual Diagnosis was consistently described by participants as a problem and it was felt that clearer care pathways needed to be developed, the remit of services in relation to alcohol and mental health clarified and a practitioner role developed which could span both presenting problems. GP and service provider participants described a 'catch 22' scenario, within which mental health services avoided

engaging with service users whom were alcohol dependent, attributing their mental health problem to their substance misuse and vice versa. Participants described the most reoccurring problem being that of a vicious circle between mental health and addiction services, with neither service taking lead responsibility for service users presenting with co-morbid problems. The following quote makes this point:

“We have difficulties with dual diagnosis, we always have difficulties with dual diagnosis because it’s you know what came first the chicken or the egg. That is a problem; mental health’s always a problem.”

ID23, Female, Service Provider, phase 1

The expectation on behalf of mental health services was seen as being to address the substance misuse problem first and then a mental health assessment could be completed. However, for substance misuse services, many individuals report using substances to help them overcome mental health problems- the implication being that if their psychiatric issues were dealt with then their substance misuse would subside simultaneously. The following extract captures this point well:

“The hospital’s a prime example coz we work with the self-harm team in the mental health services. Some of them are sympathetic to the idea of dual diagnosis and some of them just say ‘take him away, fix his drink problem and then we’ll assess his mental health’. It’s a chicken and egg situation, because they won’t stop drinking until the mental health problem’s sorted out and [you know] vice versa, and it’s just so difficult.”

ID19, Male, Service Provider, phase 1

The concern expressed by service provider participants is that for clients, who have a co-morbid diagnosis of alcohol dependence and mental health, the lack of a single point of contact can be problematic. A quote capturing this well stated *“I mean it’s frustrating for us, it must be hell on earth for the client”* (ID27, Female, Service Provider, phase 1). There was an acknowledgment that dual diagnosis services had improved, however participants emphasised that further clarity was required surrounding the remit and eligibility criteria for services in all localities. As frontline clinicians, GPs corroborated the view that issues arose for patients presenting with dual diagnosis problems, the need for a specialised role was vocalised. The following extract illustrated the issues:

“I know there’s a big gap – big, big gap – with psychiatry. I think psychiatry just doesn’t like addictions. Dunno, too hard for them. Em, but they just want....It creates work but they don’t seem to pro-actively want to manage it and want to keep it outside of psychiatry.”

ID11, Male, General Practitioner, phase 1

Individuals with dual diagnosis needs created a dilemma *“Is it an alcohol patient or is it a mental health patient?”*(ID15, Male, General Practitioner, Interview, phase 1).

GPs felt limited as to available options to offer patients presenting with co-morbid problems, leaving them powerless to offer a succinct resolution or referral on to the appropriate service, the quote below captures this feeling of helplessness well:

“Mental health services that will say sort your alcohol problem out then we will deal with your mental health problems and the alcohol services will say sort your mental health problems out and you’ll be able to work on your alcohol and were kind of stuck in the middle.”

ID14, Male, General Practitioner, phase 1

Some GP participants went a step further, stating that mental health services actively avoided taking on individuals with substance misuse issues, as identified in the following quote:

“I think the services are appalling personally. Mental health services do not want alcohol users, in fact the form marks up where they have an alcohol problem and I’ve had the experience of ringing the crisis teams to say they’ve got a drug or alcohol problem... but you know they’ve got a drug and alcohol problem and they don’t want to see them.”

ID16, Male, General Practitioner, phase 1

Dual diagnosis was described as a consistently problematic area from all stakeholder perspectives. Feelings of frustration were articulated from service user participants, with individuals experiencing significant time lags before receiving the necessary support:

“Coming back to see the crisis team on [REDACTED] just the length of time from being told to go and see them to get an appointment, to go and see these people to try and help ya, it was just astronomical. In that period of time, 5, 6, 7 months a lot of things can happen in that time, you’re very vulnerable at that time and you feel as though there’s no help out there for you. You’re stuck on a limb.”

ID55, Male, Service User, phase 1

Furthermore, some service user participants described scenarios in which they consulted their GP and received a referral for crisis counselling. A participant reported that they had not started working with the service despite 3 months passing since the referral had been made:

“Well the counselling services I think are absolutely rubbish because as I say I’m still waiting for crisis counselling which I was meant to get in, well my doctor referred me in November. Erm I’ve had 2 assessments for that and I’m still waiting so that’s nothing to me.”

ID57, Female, Service User, phase 1

There was a resounding sense of frustration and disappointment surrounding the issue of dual diagnosis, as stakeholders stated that they had continually reported problems to commissioners to no avail.

6.6 Chapter Summary

This chapter highlighted that numerous stakeholder involvement opportunities were available. For the majority of participants it was perceived that formal methods of stakeholder involvement were completed in order to collate information and contribute towards constructing a national picture regarding alcohol service provision. Informal methods of involvement were described as more innovative and personal, allowing a more flexible and pro-active approach to be taken. With regards to Arnstein’s ladder, participants articulated that the levels of involvement in alcohol commissioning *should* sit at the rungs of partnerships or delegated power. However, there was a recognition that involvement could fluctuate between rung 4 (consultation) and rung 6 (partnership).

Monitoring and unrealistic timeframes were two significant barriers described as detracting from or negating from involving stakeholders in the commissioning process. The data emerging in relation to national drivers and monitoring were somewhat contradictory. Commissioners stated that monitoring dominates commissioning within public health whilst also verbalising frustrations that monitoring was not occurring enough enabling alcohol to lose momentum and fall off the political agenda. A direct implication of the target driven method of commissioning is that stakeholder involvement was only likely to be undertaken in areas of specific interest or concern for commissioners. The notion of a 'limited timeframe' was also identified as a barrier to commissioning. The available timeframes were described as debilitating and it was stated that had the timeframes been more realistic, a bigger impact could have been made on the overall outcomes of the alcohol services commissioned.

Key challenges to involving stakeholders within the commissioning process were acknowledged. The theme of feeling undervalued emerged in relation to service users and commissioner. This runs the danger of creating a self-fulfilling prophecy, that of individuals choosing not to engage in involvement activities as it could be perceived that their opinions would go 'unheard'. Power struggles were identified with commissioners having limited influence to decommission services even if the latter were not engaging as expected with commissioners. Managing conflicts of interest were legitimate barriers for commissioners to content with as in reality the majority of stakeholders could be classed as having dual/multiple roles or identities within the commissioning process (stakeholder and service user, stakeholder and clinician). Finally, the levels of competition which occurred between service providers created challenges for commissioners to manage. Many providers described wanting to protect their own interests which led to a limited sharing of ideas and good practice resulting in treatment providers operating in a disconnected manner rather than as an integrated treatment system. When stakeholders are unwilling to work collaboratively it hampers the potential for stakeholder involvement to occur at a truly 'partnership' or 'citizen power' level as identified by Arnstein as information and ideas are not freely traded. This chapter has emphasised that although the notion of involving stakeholders in the commissioning process is advocated, a number of barrier and challenges exist which prevent it from being a straightforward process.

Chapter 7 : Discussion

7.1 Chapter Overview

The overall aim of this thesis was to explore the extent of stakeholder involvement within the context of alcohol treatment and commissioning decisions in the North East of England. This chapter presents a discussion of the analysis of stakeholder involvement in alcohol commissioning from the perspectives of commissioners, GPs, alcohol service providers and alcohol service users.

The research sought to answer the following question: 'Using alcohol services as a case study, who are the stakeholders that are involved in the commissioning process and how do they perceive their involvement in the design, organisation and delivery of frontline alcohol services?' This thesis contributes a thick description of the diverse perspectives stakeholders have regarding their involvement in the alcohol commissioning process.

Broad themes that emerged from the results are the rhetoric-reality gap regarding stakeholder involvement, obstacles to achieving consistent stakeholder involvement in commissioning and how individual attitudes and awareness shape the commissioning process. Each of these themes is discussed within section 7.2 and the findings are positioned in relation to the relevant literature. The respective strengths and limitations of the research undertaken are considered, followed by the implications of these findings for policy and practice and finally the recommendations for future research are discussed.

7.2 Key emergent themes from the research:

The key components that the thesis explored were stakeholder involvement in the commissioning process regarding alcohol service provision. The stated vision within government policy and by participants involved within this research is that stakeholder involvement within the NHS should extend well beyond the level of tokenistic participation. Involvement opportunities should surpass the perfunctory gesture of just providing advice and information to stakeholders and aspire to directly involve stakeholders in the commissioning process relating to the provision of services and ultimately setting policy priorities. The focus is on giving stakeholders increased control over commissioning decisions with particular focus being on

providing patients and members of the public a greater voice in their own care. The rationale is that the involvement of stakeholders will help to clarify the needs of the community and also enhance the patient experience (Coulter 2006, Parsons 2010). In doing so, effective stakeholder involvement will help to shape public health services that are based on choice, equity and which are truly responsive to the needs of both the individual and the community (Edwards A 2009, Tritter JM et al 2010, Dentzer S 2013, Williamson L 2014). However, the published literature and the emergent findings from the data highlight a series of persistent barriers that are hampering this development. These barriers include the reluctance on the part of 'professional' stakeholder to fully engage with the process (McKinstry B 2000, O'Connor AM, Drake E et al. 2003), the uncertainties involved in health policy setting (Jones IR, Berney L et al. 2004), the inherent complexity of the healthcare decision process and the diffidence ordinary citizens experience due to the perceived complexity of the whole process (Singer 1995, Redden 1999, Alborz and Smith 2002, Tenbensen 2002, Tenbensen T 2010). Furthermore, this research has identified the complexity associated with engaging such a diverse range of stakeholders into the commissioning process. This thesis has highlighted a range of both structural and attitudinal factors which shape the relationships between different groups of stakeholders at multiple levels.

The findings of the research presented in this thesis suggest that significant efforts should be directed towards clarifying the process, roles and responsibilities when engaging stakeholders. What is less evident within the data is exactly why engagement was being undertaken, in particular what the commissioners intend to do with the results from the engagement events and whether the involvement was intended to inform changes to practice or alcohol service design. The main themes emerging from the data are discussed below.

7.2.1 Rhetoric- reality gap regarding stakeholder involvement

A rhetoric- reality gap seems to exist between the stated intention of aiming for partnership levels of engagement and the perceived levels of stakeholder involvement actually occurring in alcohol commissioning (Litva 2002, Plunkett 2008, King 2011). In addition, there was a lack of consistency when recognising methods of stakeholder involvement, their influence on commissioning decisions and the

impact on alcohol service design and delivery. This appeared to occur due to varying levels of participant awareness regarding the meaning and purpose of stakeholder involvement in commissioning (Rudman 1996, Rose 2010).

In this study the meaning of 'stakeholder involvement' was unclear to participants and meant different things to different people. The lack of a clear recognition or identification is not surprising as in reality a stakeholder can be described as "any group or individual who can affect or is affected by the achievement of the organisation's purpose and objectives" (Cornelissen 2008:42, Tenbensen T 2010). Consequently, there is the potential for anybody to be a stakeholder, a stakeholder's identity is not static and levels of interest and influence may fluctuate over time and across the issues facing an organisation. Therefore, as Fudge (2008) identifies the meaning of the term stakeholder involvement can hold different meanings for service providers, users and policy makers depending on the individual circumstance.

This study also highlighted a lack of clear understanding surrounding the expectations and roles for stakeholders within the commissioning process. There was a lack of explicit methods of representation and little consensus about the levels of influence involvement mechanisms had regarding service design and delivery (Bruni R, Laupacis A et al. 2008, Mitton C et al 2009). In addition, the lack of a clear definition of whom a stakeholder was and the understanding surrounding appropriate mechanisms of involvement were missing. The literature and emergent data show that types of engagement can vary significantly and involvement of stakeholders can range from a one off consultation or a paper based questionnaire seeking feedback on an aspect of care to continuous involvement in the design, delivery and management of services (Plunkett 2008). From the perspective of participants within this research, a common framework did not exist for describing the key dimensions of stakeholder involvement in different healthcare decision making contexts.

Externally imposed mechanisms of stakeholder involvement were not devised specifically to reflect the local flavour but to collate information for statistical purposes or as part of a contractual obligation. The data highlighted that it was these external forms of stakeholder involvement that the majority of participants identified engaging with. However, all participants agreed that whilst they were the most commonly used method of gaining service users views, questionnaires were the

wrong tool to use to elicit information. An implication being that if external and formal methods of stakeholder involvement are the most prominent mechanism recognised, stakeholders may show limited enthusiasm to become involved. There is little published evidence about what processes and mechanisms stakeholders use within commissioning decisions to make their voice heard therefore it is hard to identify the true impact of stakeholder involvement(Mitton C at al 2009).

7.2.2 Obstacles to achieving consistent stakeholder involvement in commissioning

A number of obstacles to both commissioning per se and the involvement of stakeholders within the commissioning process were recognised by participants. The predominant issues are discussed below.

7.2.2.1 Mechanisms of engagement and stakeholder power

Interviews highlighted that numerous power imbalances are present within the commissioning system that can hinder the possibility of genuinely reaching partnership working. The acknowledgement that commissioners felt disempowered when dealing with the powerful PCT statutory service providers was insightful, as it could be expected that commissioners are the power holders due to holding the 'purse strings'. However, it was stated by Lukes (1974) that it should not be assumed that power is always in the hands of the expected power holders. This was found to be true within this research and an unequal distribution of power occurred at various levels of engagement and affected the influence stakeholders perceived they had ranging from commissioners to service users. Literature acknowledges that power differentials exist that can create barriers to stakeholders ability to influence the decision making processes(De Vos P et al 2009, Kaim B 2013). As identified by French and Raven, the location of power transfers in different circumstances according to who is perceived to be in a position of power at any given situation. The data that emerged in the thesis highlighted examples of legitimate power within which power is invested in a role that confers authority and expert power in which a stakeholder has the knowledge or skills that someone else requires(French and Raven 1960). In addition to the 'traditional' power holders, Elliott and Williams (2008) have argued that the experiential wisdom that lay people hold is a form of legitimate expertise which can become 'the basis for a powerful form of knowledge

production' adding an extra dimension within the commissioning process. As identified within the research findings and available literature, there is a growing legitimacy regarding the inclusion of the stakeholders' voice. There is an aspiration to lessen the dependency place on the voice and opinion of the 'professionals'. Available literature also acknowledges that opportunities for engagement do not always signify a legitimate transfer of power. Gaventa and Cornwall (2008: 184) state that "simply creating new spaces for participation, or new arena's for diverse knowledge to be shared, does not in itself change social inequities and relations of power". The findings within this research recognised that stakeholders had opportunities to be involved in consultation events although the power that their voices held and the impact of their involvement were uncertain. There is the potential for the voices of stakeholders whom are patients, member of the public and 'experts by experience' to become more influential as the drive towards individuals taking responsibility for their healthcare via PHBs increases and levels of consumerism within the healthcare system builds momentum. It is stated by Tritter et al (2010: 44) that "consumerism is presented as a mechanism for redressing the power inequality between health professionals and patients and as the logical extension of informed consent".

7.2.2.2 The pervasive impact of performance monitoring on commissioning

Many interviewees highlighted the excessive use of monitoring as a barrier to successful commissioning. Findings suggest that the strict adherence to centrally mandated monitoring led to undue focus on the administrative process associated with commissioning. The time dedicated to demonstrating and evidencing the achievement of commissioning principles became a lengthy process in itself detracting from other responsibilities inclusive of the engagement of stakeholders. In spite of this it was recognised that monitoring was actually a key component to maintaining focus within commissioning. This research highlighted that monitoring provided a clear direction of travel and served to keep an issue on the political agenda. However, if monitoring and commissioning priorities are highly prescriptive there is the potential to stifle innovation; there is no need for stakeholder involvement, as priorities are already identified as predefined through national drivers and monitoring. Furthermore, literature identifies that stakeholder involvement is only likely to be undertaken in areas of specific interest or concern for

commissioners, limiting the scope for involvement surrounding other areas of alcohol treatment. Additionally, the use of monitoring can be viewed as a mechanism to ensure quality of service provision, cost effectiveness and ensuring that the needs of patients are being met. In addition, a key advantage of structured data collection is the potential it offers for simplicity and consistency when reviewing commissioned services.

7.2.3 Coping with rapid and relentless change

The sheer quantity of reforms has not allowed for any commissioning policy to stabilise and become embedded in practice (Guy K and Gibbons C 2003). Throughout the thesis period (2009- 2014), commissioning within the NHS was almost continually in a state of flux and multiple changes were occurring simultaneously. Major changes included; the introduction and demise of the WCC policy, the expansion of the commissioners' roles and responsibilities from commissioning purely drug and alcohol services to commissioning an entire public health portfolio and the abolition of PCTs and the transfer of commissioning responsibility to CCGs and local authority. Alongside these major changes, almost continual episodes of restructuring were occurring. Change management literature acknowledges the impact that continual change has upon organisations from the incremental changes and small alterations to the organisation to corporate transformation at the opposite end of the continuum entailing revolutionary changes throughout the entire organisation (Dunphy and Stace 1993, Grundy 1993, Iles and Sutherland 2001).

The emerging data identified changes as constant, implying limited scope for changes to become embedded before further changes occurred. Available literature identifies that organisational change is inevitable and organisations such as the NHS need to improve efficiency and cost effectiveness and this often involves changing the way things have been done historically (Lancaster 1999). However, this continual change was identified as negatively impacting on the ability of commissioners to maintain and sustain focus regarding the commissioning process. Many of the changes to commissioning practice have been portrayed as developmental changes which Iles and Sutherland describe as "a change that enhances or corrects existing aspects of an organisation, often focusing on the improvement of a skill or process" (2001: 6). Nonetheless, the ongoing (or continual)

introduction of new commissioning policies was viewed as an unhelpful distraction by commissioning participants, preventing them from perusing and achieving longer term goals (Wilson 1992, Garvin D 1994). However, commentators such as Heifetz et al (2009) question the possibility of achieving a fixed state at all in today's turbulent environment. Data implied that the introduction of new commissioning policies had been perceived to be a developmental change, as regardless of the commissioning policy being imposed, the same processes occurred within commissioning. Despite the suggestion that each commissioning policy was merely a reiteration and rebranding of the previous commissioning process this did not appear to be wholly true as 'real' substantive changes had occurred in commissioning practice. The data emphasised that a positive element of the earlier WCC framework was that the understanding of WCC as a concept had been universal. The commissioning team commented that WCC had helped to clarify what was expected of commissioners and the understanding of commissioning concepts increased therefore minimising scope for confusion within the commissioning role.

Alongside the developmental changes that took place within the research period, transformational change also occurred, when commissioning responsibility was transferred from PCTs to the local authority. Transformational change results in "an organisation that differs significantly in terms of structure, process, culture and strategy" (Iles and Sutherland 2001: 16). Whilst many of the changes had been planned for; such as the restructuring of the commissioning team, the widening of the commissioners portfolio to incorporate multiple public health area and the transfer of commissioning to local authorities and CCGs, their occurrence still created disturbances for all stakeholders involved. It has been suggested by Jick (1995) that in environments where an organisational culture shift is being attempted, typically taking 5-7 years, the attention and momentum of change is pivotal to its success. Cultural change demands continuous reinforcement if the change is to be sustained. Individuals inevitably regress to old familiar behaviours without constant reinforcement or if the change initiator moves on (Clarke 1994). The data emerging within this research highlighted traits of commissioners reverting to type. Despite the transfer to local authorities having taken place by phase 3, previous PCT commissioners made regular references to processes and methods of working that occurred whilst under the PCT umbrella.

The longitudinal data collected highlighted the extent of changes that had occurred and emphasised the loss of organisational memory and change fatigue that was experienced during the transformational periods. This research identified that participants withhold a wealth of tacit knowledge that is intuitive and resides in their cognitive thoughts as opposed to being stored in an external repository waiting for the next employee to access it. Commentators recognize that tacit knowledge is not easily shared therefore, with each re-structure of an organisation or loss of an employee, the organisational memory is affected, with individuals taking important knowledge and experience with them as they depart (Huber 1991, Stein 1995, Wang 2006). Significant alterations had occurred both within the commissioning team structures and regarding the available alcohol treatment services, therefore it is likely that the organisational memory will have been affected resulting in the organisational memory being weakened.

When discussing the concept of continual change all commissioning participants expressed concerns around the associated 'realistic time frames'. The tight timeframe was viewed as debilitating and participants stated that if the timeframe had been more realistic, a bigger impact could have been made on the overall outcome of the alcohol services commissioned. Participants felt that short timescales were not conducive to conducting a systematic need assessment relating to alcohol services alongside not allowing scope for continual stakeholder involvement to occur. It is suggested in the literature that change should be perceived as "a continuous, open ended process of adaptations to changing circumstances and conditions" (By 2005: 375). These observations hold true within the NHS and the commissioning of a public health issue such as alcohol will always have to respond to changing circumstances. Therefore, time constraints will always be present within public health commissioning and it could be argued that if commissioners worked pro-actively instead of reactively then tight timescales would not be a barrier. Furthermore, if stakeholder involvement occurs on a regular basis and networks are already established, the views and opinions of stakeholders could be sought within a relatively short timescale.

7.2.4 How individual level attitudes and awareness shape the commissioning processes

The emerging data highlighted how the attitudes of individual stakeholders could be pivotal when shaping the commissioning process. GPs were one specific group of stakeholders to emphasise this point. Limited motivation has been identified both within this research and the wider literature on behalf of GPs to become involved in the commissioning process (Sabey A and Hardy H 2013). Whilst the accounts of single GPs cannot represent the entirety of views and experiences of a complete group of clinicians; it was nevertheless clear that the GPs interviewed reported a lack of motivation and awareness of the significance of clinicians to become involved in the commissioning process. When considering whether stakeholders wanted to be involved in commissioning decisions, the majority of participants within this research showed an awareness that not all stakeholders will prioritise involvement in alcohol commissioning over their core day to day business. However, GP participants within this study explicitly described that involvement in the commissioning processes was not seen as a pivotal part of day to day business. Many GPs were led by their patients' needs and the familiar individual v population argument was relevant here (Arah O 2009). Some GPs had a passive attitude to commissioning and they substantiated their lack of involvement in commissioning by providing justifications regarding the 'other' roles they were involved in (Howe A, Stone S et al. 2012, Newman P 2012). Furthermore, there was a lack of commitment to the wider population to address the issues surrounding alcohol misuse. For some GPs the prospect of undertaking economic activities such as rationing had the potential to detract from the doctor-patient relationship (Kearley K, Freeman G et al. 2001, Mahmud A 2009).

There was a resignation for the GP participants interviewed that only a few people chose to get involved in commissioning, thus leaving the onus on a minority of GPs who have an interest in the subject area or feel obligated to contribute. Those GPs that did not want to be involved were considered to be in the majority, with a few enthusiastic GPs being in the minority. This finding is consistent with recent literature regarding GP motivation to be involved in the new commissioning structures (British Medical Association 2012, Sabey A and Hardy H 2013). Although only a small sample was recruited the data highlights some of the potential problems that may

arise in relation to commissioning as GP become one of the main stakeholders and commissioners of services.

Alongside the variable levels of motivation to be involved in commissioning, a lack of awareness surrounding the commissioning process outside of the immediate commissioners' role was identified within the research. The PCT/LA commissioner participants (Commissioning participants sat within the PCT at phase 1 and 2 and within the LA by phase 3) conveyed up to date knowledge of the process involved and policy changes taking place. In addition, GP participants were also aware of commissioning policy due to the policy changes surrounding commissioning responsibility transferring to clinical commissioning groups. The knowledge diminished among other participants with service providers and services users appearing to have little awareness of what the commissioning process involved. The limited understanding on behalf of participants highlights the lack of clarity surrounding commissioning terms. As stated in chapter 2, the term commissioning is ill defined and the terms 'contracting', 'purchasing', 'procurement' and 'commissioning' have all been used interchangeably within the NHS lexicon contributing to the confusion for many stakeholders (NHS Commissioning Board 2012). Each term can denote different meanings: in some instances purchasing can imply purely a procurement function; whilst in other instances it can include a far broader set of activities (Lewis, Smith et al. 2009) the difference between terms can be misconstrued for stakeholders outside of the immediate commissioning role.

The majority of participants alluded to their involvement in shaping service design, contributing to consultations and/or being involved in monitoring exercises all of which touch upon aspects of the commissioning process. This could be viewed as a positive finding as there is an implication that the majority of participants felt that they had had some involvement in engagement events at some point. However, the same participants did not explicitly show an understanding of the complete commissioning process inclusive of strategic planning, procurement, monitoring and evaluation of providers. Without this appreciation for the entire spectrum of activities undertaken by commissioning, it is hard to establish whether stakeholders have been involved in the process or not.

Finally the interviews identified that concerns were discussed surrounding the challenge of engaging stakeholders with multiple roles and identities in the commissioning process. Although this area of concern should not be ignored or minimised, it potentially shows a lack of awareness regarding the reality of commissioning in public health. In many scenarios it is the dual role identity that is a particular strength for most stakeholders. Available literature identifies conflict of interest as an area that needs to be managed appropriately however with regards to a subject area as complex as alcohol misuse, the majority of stakeholders bring skills, knowledge and experience due to their multiple roles and identities.

7.3 Interpretation of findings

This doctoral study has sought to explore the perceived influence of stakeholder involvement in commissioning by examining the stakeholders own perspectives on, and experiences of, being consulted regarding the design and delivery of alcohol services. Arnstein's ladder of engagement (1969) as identified in figure 6, section 3.5 was used in an attempt to categorise the types of involvement that were happening in alcohol commissioning, whilst also considering the levels of perceived influence power holders had regarding stakeholder involvement. The ladder of engagement was relevant to each level within the hierarchy of decision making. Fundamentally the local authority and CCGs occupy the top rung and hold the position of citizen control. They have possession of delegated power in which they delegate the 'responsibility' of commissioning. However, the findings chapters highlighted the common and perceived sense of feeling powerless on behalf of some commissioners as the level of influence from governmental policies resulted in PCTs not being sufficiently powerful to exert the control required to manage commissioning. The government delegated the power in a restricted manner setting targets for the commissioners to adhere to, severely restricting the levels of autonomy held by commissioners. Due to the rigid performance management style resources were instantly allocated to issues dictated to by the government resulting in limited flexibility to allocate resources on objectives identified locally by stakeholders within the strategic plan.

Some power struggles were portrayed in relation to services purchased directly by commissioners with PCT providers being described by participants as having

substantial knowledge and being 'strong' stakeholders. An example of expert power was portrayed wherein the PCT statutory providers hold the skills and knowledge to overpower the commissioners (French and Raven 1960). Within these scenarios PCT commissioners often felt powerless to influence or control activity levels within foundation trusts and even when contractual obligations were not being met there was limited scope to decommission. Furthermore, within the commissioning teams, relationships were based on the notion of command and control, with senior management being the power holder suggesting that compliance with targets was mandatory. Even with regard to the commissioning team who hold ultimate responsibility for commissioning decisions, discrepancies arose regarding whether collaborative decision making actually occurred. Acknowledgement was made by commissioners that decisions should include consultation with all members of the commissioning team. In reality, participants described one member of the commissioning team as driving the decisions forward and being influential in controlling the direction of travel due to their senior status. Participants that were lower in the 'chain of command' were prepared to accept that colleagues with more power could and would influence the decisions. The high level of coercive power and imposed decisions made it harder for participants to draw on local knowledge and design a treatment system that reflected the 'local flavour'. The implication being that despite commissioners being perceived to be influential, certain decisions were imposed on these stakeholders and they had to follow a prescribed method of working. The seeming enforced ways of working have the potential to stifle the motivation for some professional groups of stakeholders to be involved and/or engage fully as consultation is not perceived as genuine.

The commissioners interviewed identified themselves as an 'expert' within regards to the commissioning of alcohol services. However, whilst acknowledging their expert status there was still recognition that commissioning is a democratic process. Commissioning participants stated that they attempted to involve stakeholders and work in partnership with their fellow public health colleagues in an attempt to reduce the levels of alcohol related harm being experienced in the North East. Commissioning participants placed levels of stakeholder involvement at the 'partnership' rung. Although, despite being labelled as partnership working with professional stakeholders, the commissioners still held the budget and had the final

say in decisions. The opportunity to impact upon service provision was available as long as it occurred within budget restraints and contract agreements already imposed by the commissioners. In reality, much engagement and proposed 'involvement' of partner agencies and clinicians regarding decision making occurred at the tokenistic level of placation or consultation. The implication being it was more about tweaking the system as opposed to significant influence over commissioning decisions.

The clinicians (general practitioners and service providers) described a more varied perspective when considering the current position of stakeholder involvement. This variability in the perspective of clinicians is not surprising as these participants are both in direct contact with patients and members of the public whilst also being a stakeholder themselves subject to commissioning decisions. The majority of 'professional' stakeholders (commissioners, GPs and service providers) stated that the levels of stakeholder involvement in alcohol commissioning should sit at the rungs of either partnership or delegated power however, views varied as to where it actually sat. There was recognition that involvement could fluctuate between rung 4 (consultation) and rung 6 (partnership). The upper most rung of Arnstein's ladder, citizen control was not perceived to be conducive to genuine stakeholder involvement and none of the participants interviewed implied that they thought control should be held by any one individual or group. However, the intention behind the introduction of personal health budgets would be; to encourage individuals to reach the citizen control rung and take ultimate control over the care package that they receive.

Clinicians explained that they aspired to reach partnership working with regards to service user involvement at a micro level within individual treatment services. Although in reality the data showed that the majority of service user involvement occurred at the level of consultation and even when voices were given an opportunity to be involved, ultimately the level of influence was unknown as it was not specifically reported on or monitored at a macro level. At the most limited level, manipulation could be seen as service users were provided with a treatment option or received treatment that did not meet their stated needs. The findings reinforced

that despite all groups involved in the research being stakeholders, some are more powerful than others due to their different roles and responsibilities.

The majority of service users described involvement at the levels of therapy or informing, signifying a level of tokenism, despite the data suggesting something quite different at times as opportunities for service user involvement to occur were described. Participants described feelings of disillusionment as professionals' technical expertise often seemed to be used as a source of power when liaising with service users. The widely held perception of participants emphasised that they were 'experts by experience' and their voice should be accorded a high level of validity when considering service design and delivery. Despite describing limited scope to influence commissioning, two examples of a progression from service user to service manager were described. These specific scenarios identified working examples in which current managers had identified gaps in their own treatment journey when they were a service user. De vos et al (2009) identified that it is possible for marginalised groups to influence power relations and pressure power holders into action. The examples discussed within this research reinforced that it is possible for individuals regardless of their status to influence commissioners and provided an example of citizen control.

Some service users expressed feelings of being stigmatised and stated that due to having a substance misuse problem their voice was not heard and not respected. Participants explained that their opinion is only taken into account once an individual is recovering; it was unclear whether this was actually the reality. Many service user respondents described feelings of disempowerment and a lack of involvement opportunities to influence either their treatment or commissioning decisions. It could be argued that a general feeling of futility in treatment could extend or extrapolate to commissioning or even broader service running. A factor for consideration regarding service users as stakeholders is whether it can be substantiated that an individual in the thick of treatment (particularly in an area as tricky as alcohol dependence) can achieve sufficient distance to be able to speak for many service users (known and unknown) to help shape wider commissioning decisions?

Key interviewees revealed that there often seemed to be no prescribed method for conducting stakeholder involvement and limited guidance of the most appropriate

method of involvement to use was lacking. Rather involvement appeared to be present in several forms and serve multiple purposes (i.e. therapeutic, service development, complaints) consequently it was hard to establish the levels of power and influence held within each scenario. This is hardly surprising as the concept of stakeholder involvement is more complex than the current theoretical models portray within the literature. This research did not aim to refute Arnstein's model, or to propose it as an ideal model within alcohol commissioning. Rather this study aimed to expand the understanding of the concept, and some amendments to Arnstein's ladder are proposed in figure 13.

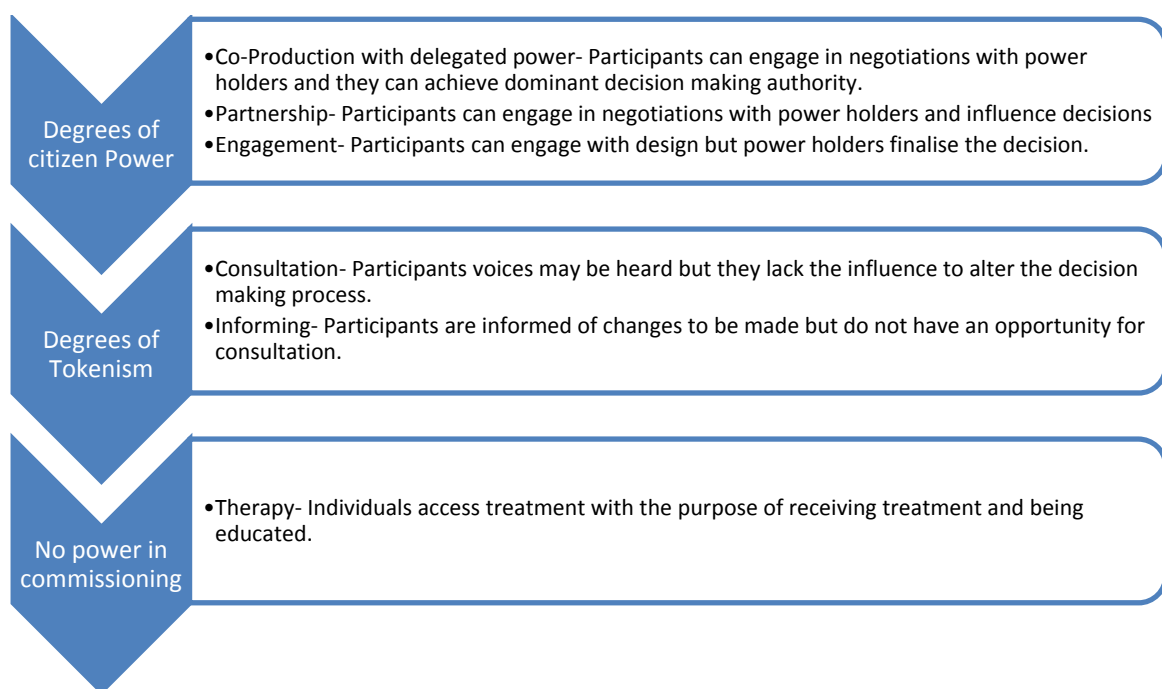


Figure 13: Proposed adaptations to Arnstein's ladder

This thesis proposes that the upper most rung of the ladder is co-production within which the stakeholder can achieve dominant decision making authority. This research proposes an adapted ladder suggesting that there is a hybrid between co-production and delegated power as within the commissioning environment, an individual has to take control of the resources and be accountable for the decisions made. For the majority of stakeholders regardless of their status as commissioners, professionals or service users, the aspiration seemed to be for involvement to occur at either the partnership or co-production level.

However, the introduction of personal health budgets (PHB) and the idea of personalisation and self-directed support emphasises the desire of policy makers to move to 'citizen control'. The topic of PHBs could create an area of contention regarding the newly proposed ladder. The purpose of PHBs are to allow people to have much more control over how their needs are met, providing them with control regarding which services they receive and who delivers those services. However, even within a policy clearly aiming to pass over the power to individuals a number of features still encourage that co-production still takes place. For instance the Department of Health identifies 5 essential features of a PHB, one of which states the budget holder should "be able to choose the health and wellbeing outcomes they want to achieve, in agreement with a health care professional"(Department of Health 2012c). Furthermore, in a paper published by the Nuffield Trust it is stated that "clinical sign off of the public health budget ensures that clinicians are comfortable that all aspects of the care plan are safe and likely to help the individual to meet their chosen Health and Wellbeing goals"(Alakeson and Rumbold 2013). The implication of the policies still promote that the end plan of care is co-produced. This is a very important factor to take into consideration when considering a complex public health issue such as alcohol misuse. If service users are drinking at dependent levels, problems may arise regarding levels of intoxication, cognitive impairment and mental health problems all of which may impact on an individual's ability to identify appropriate outcomes to purchase with their personal health budgets should they be allocated one.

7.4 Key strengths and limitations of research

A number of potential strengths and limitations can be present within research; the topics relevant to this study include the issue of reflexivity, validity, the use of gatekeepers and the transferability of the findings. Each topic is discussed below.

7.4.1 Reflexivity and practitioner research

Reflexivity is particularly important within all research studies and particularly in the qualitative paradigm as the researcher is the key analytical instrument. Reflexivity is "the continuous process of reflection by the researcher on his/her own values, preconceptions, behaviour or presence and those of the respondents, which can affect the interpretation of responses" (Parahoo 2006: 326). Alongside my role as

researcher within which the primary interest is to generate and disseminate reliable research, a secondary interest is my current role as a substance misuse practitioner working within alcohol treatment agencies. Therefore, it is important to acknowledge the potential influence of 'practitioner research', which is described as research conducted by practitioners, as insiders within their own profession (Fuller and Petch 1995, Jarvis 1998).

Of importance within this thesis was the recognition of my own social constructions, which have been influenced by both my professional and personal experiences. I do not consider myself to be independent of the research as I have ten years' experience of working as a drug and alcohol practitioner. Due to my insider knowledge of service users and the alcohol treatment system I was placed in a unique position. I believe that my prior knowledge enabled me to promote authority and authenticity within the data collection proceedings. I only had limited experience of conducting qualitative research and was solely responsible for conducting the interviews and focus groups. However, inevitably due to my practitioner background previous experience, knowledge and understanding were brought to the research context. In an attempt to minimise the levels of influence my identity had on the research I did not disclose my prior knowledge to participants. This prompted participants to provide a thick description of their experiences rather than making the assumption that explanations were not required as I already 'understood' due to my background.

Commentators such as Bonner and Tolhurst (2002) state that practitioner research can allow prior knowledge to be built upon more quickly than a total stranger entering the field. Although equally a researcher's tacit knowledge if left unchecked may lead to false assumptions or misinterpretations of the data being made. In an attempt to minimise the influence I had upon the research process my pre-conceived assumptions were challenged throughout the research. Risks were managed by undertaking regular supervisory meetings to discuss the emerging data and discussing the findings with academic colleagues.

Sommer and Sommer identify that, due to human interaction within the data collection process, data are highly subject to researcher bias. The researcher is "not neutral, distant or emotionally uninvolved" (Rubin and Rubin 1995: 12), resulting in

the interview being affected by the researcher's personality. Although put forward as a weakness by Sommer and Sommer(1997), it can be argued that individual interpretation is the essence and strength of qualitative methodology. This research provides a coherent and plausible account of the phenomena being studied and the rationalisation of the methods used.

Whilst trying to ensure that the data presented are accurate and credible, it is important to acknowledge potential limitations regarding data analysis. One such limitation is that only one individual conducted the interviews and analysed the data. This is therefore open to individual interpretation and bias. Within this thesis the levels of bias have been minimised as much as possible by making the analytic process as transparent as possible to academic colleagues and working closely with a supervisor to ensure that the interpretations of the data were not influenced unduly by my practitioner status. The data analysis process, inclusive of emerging categories and findings were presented to academic audiences through discussion forums, supervisory meetings and conferences to enable dialogue to occur. Finally, the use of verbatim quotes within the findings has the potential to increase dependability and highlight that the interpretation is grounded in the data (Johnson 1997).

The inclusion of longitudinal data collected during a period of enormous structural change within the NHS provides a unique perspective and provided an additional depth and credibility to the qualitative work. The findings that emerged emphasised the complexity of the subject area highlighting that the thoughts and feelings that participants expressed about a specific issue were highly time and context contingent. The sequential design ensured that findings from one research phase informed the next. The addition of phase 2 and 3 data within which participants were revisited provided a different perspective which would have gone unnoticed if only phase 1 data collection had occurred. The completion of data over a prolonged period enabled the research to witness how issues such as changing commissioning policies and organisational change destabilises the commissioning process and how individuals' perceptions alter in accordance with their current environment.

7.4.2 Validity

Validity refers to the plausibility and ‘truthfulness’ of the findings(Whittemore, Chase et al. 2001)in addition it involves taking into account the amount and kinds of evidence used to support the claims made (Hammersley and Atkinson 1995). Methods to enhance the validity of this research included providing the reader with a clear and concise justification of methods used, using NVivo to assist in the qualitative data analysis, including a reflexivity section and undertaking respondent validation. With regards to respondent validation, brief reports highlighting the key themes and findings were circulated to all commissioners, service providers and GPs, providing an opportunity for authenticity of data to be sought. Furthermore, dyad/triad interviews were conducted with commissioners to provide a forum for the initial research findings to be showcased to participants. The circulated reports and the dyad/triad interviews provided participants with the opportunity to discuss the emergent themes and challenge any data they felt had been misinterpreted. Respondent validation allowed the interim findings to be cross checked with respondents and the reactions/feedback from the findings (both verbal and written) was incorporated to help refine explanations within the thesis (Barbour, 2001). In addition research findings were discussed within supervisory meetings, at conferences and discussion forums. Feedback occurred verbally and was incorporated where appropriate within the findings chapters.

Under the umbrella of validity, the issue of the sample recruited within the study was acknowledged. The refusal by Directors of Public Health (DPH) to be involved in the research at both phase 1 and phase 3 was worthy of note. Despite the research clearly being described as commissioning within public health and alcohol being the case study, each director of public health immediately signposted to the drug and alcohol joint commissioning manager as they had the ‘specialist’ knowledge that the research required. It is well documented that the consequences of alcohol related harm are far reaching and touch upon a multitude of other public health areas therefore DPH were approached to obtain that broader insight into how alcohol interventions fit within the public health agenda.

Within the recruitment process only a small sample of GPs agreed to participate. The research would have benefitted from obtaining the perspectives of more ‘jobbing’

GPs to enable a wider understanding of an individual's knowledge and skills in these areas to be sought. GPs without experience in these subject areas did not respond to invites at all or replied providing a name of a local GP who did have the 'expert' knowledge. However, 5 out of 6 GPs whom did contribute had specialist knowledge of alcohol and/or commissioning therefore provided an insightful perspective into GPs involvement in alcohol commissioning. The data highlighted how incomplete the knowledge regarding the key areas of stakeholders, commissioning and alcohol were within the GP group. The implications of this lack of awareness could be far reaching now that commissioning responsibility has been partly transferred to CCGs.

Despite a blanket invite to service users regardless of tier of service, the recruitment process resulted in a limited sample of participants only attending tier 1 and tier 2 services. The majority of service users were accessing or had accessed tier 3 and 4 services (structured psychosocial interventions/medical detox and residential rehabilitation). The limited recruitment of services users from all tiers of service means that the findings may not be representative of all stakeholders who could potentially be involved alcohol commissioning. Although the participants whom did attend the focus groups had a good understanding of alcohol service provision and provided large quantities of information relevant to the research study.

The use of gatekeepers within research has the potential to either help or hinder the research depending upon an individual's personal beliefs on the validity of the research(Reeves 2010). Therefore, the issue of validity was an important issue to be aware of when considering the use of gatekeepers within the research. Gatekeepers were approached who were enthusiastic about the research and were willing to invest time to help co-ordinate the focus group or facilitate access to participants. A GP who had specialist knowledge of both alcohol and commissioning acted as a gatekeeper for accessing GP participants. A service user involvement officer acted as a gatekeeper for accessing alcohol service users and an alcohol commissioning officer volunteered to facilitate access to commissioning colleagues and alcohol service providers. These gatekeepers were extremely important when recruiting participants as they provided an access route to otherwise potentially hard to engage participants.

A number of mechanisms were used to minimise the influence the risks identified above had on the data. Throughout the research, findings were discussed with a variety of audiences, authenticity checks were conducted and data was placed in repositories where other colleagues could access it. Furthermore, the processes were clearly documented therefore there was a transparency of the approaches used with the research.

A final area of consideration regarding the validity of the research was its transferability. This research focuses on alcohol services within the north east of England. Due to the study covering one specific geographical area the descriptions provided and the findings that emerged may not be transferable to other commissioning teams across England. Despite, the research predominantly being focused on commissioning within the PCT context the main findings regarding the stakeholder involvement in commissioning are transferable to the new public health architecture. Attempts were made to enhance the transferability of the research by describing the research process. Undertaking a comparable study inclusive of a number of regions would increase the generalizability of the findings, as well as identify any regional differences.

7.5 Recommendations for policy

The findings of this doctoral research have several important implications for policy and practice relating to the use of stakeholder involvement in commissioning decisions.

Whilst the stakeholders interviewed appeared to demonstrate an awareness of the key role stakeholders can play in commissioning; the adoption and delivery of stakeholder involvement mechanisms and techniques remains somewhat piecemeal. This study suggests two important areas of future work:

First, there is a clear demand for improved education on the best ways to identify and engage stakeholders in different healthcare decision making contexts. Alongside the demand for improved education on behalf of stakeholders around the limitations and challenges associated with including the stakeholders' voice in commissioning.

One key interpretation of this research is that participants identify/focus on certain types of stakeholders for example doctors predominantly referred to patients, providers referred to service users and commissioners made reference to professionals. There needs to be further awareness of the entire spectrum of stakeholders as opposed to individuals undertaking a narrow focus when attempting to involve stakeholders within the commissioning process. The transfer of commissioning responsibility to local authorities may offer an opportunity for an increasingly diverse range of public health stakeholders to be approached to engage in commissioning. In many respects due to the local authority's wide scope and responsibilities they are better placed than the NHS whom had a largely clinical orientation to address the broad range of determinants necessary to commission public health issues.

Secondly, many participants articulated their resistance to overly formalised, prescriptive interventions, preferring instead what they considered to be a more innovative approach. Therefore, policy needs to consider developing more appropriate and sustainable mechanisms of involving stakeholders in the commissioning process.

7.6 Areas for future research

This study focused on the perspectives of individuals directly involved with specialist alcohol treatment services. However, findings from both the research and available literature have highlighted the diverse spectrum of potential stakeholders who could potentially be involved in the commissioning process. Future research should target a more diverse group of stakeholders providing and accessing tier 1 and 2 alcohol interventions, this would arguably generate a fuller understanding of the influence of stakeholder involvement in its entirety.

The study of alcohol commissioning is a complex area to investigate, further interrogation of stakeholder involvement in an area of public health other than alcohol misuse would potentially help to identify whether the perceived levels of engagement and the barriers to stakeholder involvement in commissioning occur in other areas of public health or whether they are specific to the alcohol field. Additionally, future research could employ alternative data collection methods such

as observations to facilitate increased understanding of the commissioners' approach to involving stakeholders within the commissioning process.

This study identified varied perspectives as to the levels of stakeholder engagement that were currently taking place. Future research is needed to identify whether the adapted version of Arnstein's ladder is transferable to the subject of stakeholder involvement in alcohol commissioning. Whilst also investigating whether it is possible for stakeholder involvement to take place at the levels of partnership and co-production with regards to such a complex public health issue.

Finally, this study has served to underline the continued challenges associated with a constantly changing environment. This research was undertaken within a context where commissioning responsibility transferred from PCTs to local authority and CCGs. Future research would be able to provide a contrasting view of how alcohol commissioning had altered since the transfer to local authority and alcohol becoming just one of the streams under the public health umbrella.

7.7 Conclusion

Overall, the data is suggestive of a degree of success in the various policy initiatives introduced in recent years to stimulate an awareness of the *aspiration* of including the stakeholders voice within the decision making process. There is a need to generate a deeper understanding of who stakeholders are within public health and what stakeholder involvement in commissioning actually is to maximise its utility. The findings from this research have served to highlight that some inconsistencies regarding an individual's knowledge *of* and desire *to* participate in stakeholder involvement opportunities within the commissioning process exist. Thus participation in commissioning decision making may be more or less enabled by stakeholders. This warrants further thought to developing a mechanism to identify who stakeholders are and the most appropriate way to introduce them to the commissioning process.

Policies advocating stakeholder involvement in commissioning decisions do not give clear guidance about what participation is or should be. Furthermore, the range of models presented in the literature, create a diverse picture of what participation might be and importantly what actions and skills might be necessary to achieve it. If

policy makers and commissioners are serious about encouraging and strengthening stakeholder involvement in the commissioning process, this research would lend additional support to identifying methods of involvement that are perceived to show a genuine commitment to hearing the stakeholder's voice. This research has highlighted that a clearer understanding regarding the most appropriate methods of engaging stakeholders at the various stages within the commissioning process is needed. This warrants further consideration in developing more appropriate and sustainable mechanisms of involving stakeholders in the future.

Numerous opportunities for stakeholder involvement to occur were identified; however, the actual influence of stakeholder involvement on service design and delivery was not unclear. Therefore, the question of the adequacy of the frequency and appropriateness of mechanisms to support the evaluation of these engagement events are currently ambiguous. Further consideration regarding the introduction of appropriate mechanisms to enable the effectiveness of the stakeholder mechanisms used needs to occur.

Appendices

Appendix 1: Participant Information Sheet for interviews and focus groups (Phase 1 and 2)

Research Study: Alcohol Treatment and Commissioning.

Chief Investigator: Hayley Alderson

We would like to invite you to take part in our research study. Before you make a decision please take time to read the following information carefully; it will provide details on why the research is being conducted and what it will involve for you. Part one of this sheet explains the purpose of this study and what will be expected of you if you agree to take part. Part two gives you more detailed information about the conduct of the study. I will go through this information sheet with you, please feel free to ask me questions if there are anything you are unsure about or if you would like further information. This should take 10-15 minutes.

Part One

What is the purpose of the study?

Excessive drinking is the third greatest risk to public health in developed countries such as the UK. The North East Alcohol office, Balance, produces statistics that show alcohol misuse, costs the North East region more than £1 billion a year. The North East has one of the highest prevalence rates for excessive drinking and alcohol related health inequalities and the South of Tyne and Wear have been identified as one of the areas worst affected by alcohol related harm in England. It has also been identified that for every £1 spent on treatment, the public sector will save £5. Thus responding to alcohol misuse and alcohol related harm has become a major public health priority.

The introduction of the World Class Commissioning competencies and the vision to transform the way health services are commissioned, envisaging a more strategic approach and a clear focus on delivering improved health outcomes is an integral element to this study. Thus information about the commissioning of services will be considered against the framework governed by the 11 competencies of World Class Commissioning.

The aim of this research is to investigate the impact of commissioning policies on alcohol service design and delivery.

Why have I been invited?

You have been invited to take part in this study because you are a key member of staff, with the ability to provide knowledge and insight, into the commissioning, delivery or development of alcohol treatment interventions.

Do I have to take part?

It is your decisions whether you decide to join the study and taking part in the research is entirely voluntary. If you agree to participate, confidentiality would be

discussed and I will then ask you to sign a consent form. If you agree to participate, you are still able to withdraw from the study at any time, without providing a reason and without your legal rights being affected.

What will happen if I take part?

If you decide to take part, one single (one to one) interview will take place at a time, date and location appropriate for you. I will conduct the interview in a face to face situation and it will last no longer than 60 minutes. Once completed, your involvement in the research will end. There is no longer term follow up. The interview will be recorded but none of your personal details will be identified. The recording will then be typed up so that I can analyse the results.

OR

You will take part in one single focus group with up to 15 other participants. I will facilitate the group and it will last no longer than 90 minutes. Once completed, your involvement in the research will end. There is no longer term follow up. The interview will be recorded but none of your personal details will be identified. The recording will then be typed up so that I can analyse the results.

What are the possible disadvantages and risks of taking part?

I do not see any risks for you taking part in this study and the only possible disadvantage is that you are giving up some of your time. I acknowledge that, although highly unlikely, talking about certain issues may be distressing or uncomfortable for you. However, if this happens, assistance will be provided to resolve the situation.

What are the possible benefits of taking part?

The benefits of this research are to the NHS in general and not to specific research participants. However, it may be of benefit to you to know that your views are being listened to and are valued.

What if there is a problem?

Any complaint you may have about the way the study is being conducted will be addressed. The detailed information is given in part two.

Will my taking part in this study be kept confidential?

Yes. I will follow ethical and legal practice and all information about you will be handled in confidence. The interview data will be kept confidential and reported anonymously. Any direct quotation will be attributed to general job title only (e.g. "Service Manager A").

The information collected will be stored securely in locked university offices, computers will be password protected. The interviews will be recorded and transcribed. In line with the Newcastle University's code of conduct for research, the interview transcripts will be destroyed ten years after publication of the study's findings.

If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

Part Two

What will happen if I don't want to carry on with the study?

You can withdraw from the study at any time. Information we have already collected with your consent will be retained and used in the study. Withdrawal from the study will not affect your legal rights.

What if there is a problem?

If you have a concern about any aspect of the study, you should contact me and I will do my best to answer your questions. Contact details are:

Mrs Hayley Alderson
Newcastle University
Institute of Health and Society
Baddiley-Clark Building
Newcastle University
Richardson Road
Newcastle upon Tyne
NE2 4AX

Telephone: 01912223814 email: Hayley.peacock@newcastle.ac.uk

If you remain unhappy and wish to complain formally, you can do this via the Research and Development Manager of the appropriate NHS organisation.

What will happen to the results of the research study?

This research will be used as a Doctoral Degree project (PhD) and will be submitted to examiners at Newcastle University. Research papers and conference presentations will also be produced. Participants will receive a summary of the findings after the final report has been disseminated.

Who is organising and funding the research?

The Research is funded by NHS South of Tyne and Wear. The research is organised by experienced academics from both Newcastle and Durham Universities with specific research expertise on Alcohol and Public Health, Health Economics and Commissioning. The research is taking place within FUSE (the Centre for Translational Research in Public Health).

Who has reviewed the study?

All research in the NHS is looked at by an independent group of people, called a Research Ethics committee, to protect your interests. This study has been reviewed and given favourable opinion by Sunderland Research Ethics Committee.

How can I get further information?

If you would like any further information please do not hesitate to contact Hayley Peacock (see above).

Thank you for taking the time to read this information sheet.

Appendix 2: Interviews Participant Information Sheet (Phase 3)

Research Study: Alcohol treatment and commissioning

Chief Investigator: Hayley Alderson

I would like to invite you to take part in my research study. Before you make a decision please take time to read the following information carefully; it will provide details on why the research is being conducted and what it will involve for you. Part one of this sheet explains the purpose of this study and what will be expected of you if you agree to take part. Part two gives you more detailed information about the conduct of the study. I will go through this information sheet with you, please feel free to ask me questions if there are anything you are unsure about or if you would like further information. This should take 10-15 minutes.

Part One

What is the purpose of the study?

Excessive drinking is the third greatest risk to public health in developed countries such as the UK. The North East Alcohol office, Balance, produces statistics that show alcohol misuse, costs the North East region more than £1 billion a year. The North East has one of the highest prevalence rates for excessive drinking and alcohol related health inequalities and the South of Tyne and Wear have been identified as one of the areas worst affected by alcohol related harm in England. It has also been identified that for every £1 spent on treatment, the public sector will save £5. Thus responding to alcohol misuse and alcohol related harm has become a major public health priority.

During the course of this research primary care commissioning has evolved and the emergence of a coalition government in May 2010, led to radical changes leading to PCTs and SHAs being abolished alongside World Class Commissioning which was the original focus of this thesis. However, despite experiencing significant transformation, government initiatives, policy documents and legislation have consistently supported the concept of stakeholder involvement in all stages of commissioning for health and wellbeing. Evidence suggests that when clinicians are involved in commissioning it results in a more efficient use of resources, higher quality of care and better patient experience.

The aim of this research is to use alcohol services as a case study to investigate who are the stakeholders that are involved in the commissioning process and how do they perceive their involvement in the design, organisation and delivery of frontline alcohol services.

Why have I been invited?

You have been invited to take part in this study because you are a key member of staff, with the ability to provide knowledge and insight, into stakeholder involvement in the commissioning, delivery or development of alcohol treatment interventions.

Do I have to take part?

It is your decisions whether you decide to join the study and taking part in the research is entirely voluntary. If you agree to participate, confidentiality would be discussed and I will then ask you to sign a consent form. If you agree to participate, you are still able to withdraw from the study at any time, without providing a reason and without your legal rights being affected.

What will happen if I take part?

If you decide to take part, one single (one to one) interview will take place at a time, date and location appropriate for you. I will conduct the interview in a face to face situation and it will last no longer than 60 minutes. Once completed, your involvement in the research will end. There is no longer term follow up. The interview will be recorded but none of your personal details will be identified. The recording will then be typed up so that I can analyse the results.

What are the possible disadvantages and risks of taking part?

I do not see any risks for you taking part in this study and the only possible disadvantage is that you are giving up some of your time. I acknowledge that, although highly unlikely, talking about certain issues may be distressing or uncomfortable for you. However, if this happens, assistance will be provided to resolve the situation.

What are the possible benefits of taking part?

The benefits of this research are to the NHS in general and not to specific research participants. However, it may be of benefit to you to know that your views are being listened to and are valued.

What if there is a problem?

Any complaint you may have about the way the study is being conducted will be addressed. The detailed information is given in part two.

Will my taking part in this study be kept confidential?

Yes. I will follow ethical and legal practice and all information about you will be handled in confidence. The interview data will be kept confidential and reported

anonymously. Any direct quotation will be attributed to general job title only (e.g. "Service Manager A").

The information collected will be stored securely in locked university offices, computers will be password protected. The interviews will be recorded and transcribed. In line with the Newcastle University's code of conduct for research, the interview transcripts will be destroyed ten years after publication of the study's findings.

If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

Part Two

What will happen if I don't want to carry on with the study?

You can withdraw from the study at any time. Information we have already collected with your consent will be retained and used in the study. Withdrawal from the study will not affect your legal rights.

What if there is a problem?

If you have a concern about any aspect of the study, you should contact me and I will do my best to answer your questions. Contact details are:

Mrs Hayley Alderson
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Telephone: 01912223814 email: Hayley.peacock@newcastle.ac.uk

If you remain unhappy and wish to complain formally, you can do this via the Research and Development Manager of the appropriate NHS organisation.

What will happen to the results of the research study?

This research will be used as a Doctoral Degree project (PhD) and will be submitted to examiners at Newcastle University. Research papers and conference presentations will also be produced. If requested participants will receive a summary of the findings after the final report has been disseminated.

Who is organising and funding the research?

The Research is funded by NHS South of Tyne and Wear. The research is organised by experienced academics from both Newcastle and Durham Universities with specific research expertise on Alcohol and Public Health, Health Economics and

Commissioning. The research is taking place within FUSE (the Centre for Translational Research in Public Health).

Who has reviewed the study?

All research in the NHS is looked at by an independent group of people, called a Research Ethics committee, to protect your interests. This study has been reviewed and given favourable opinion by Sunderland Research Ethics Committee.

How can I get further information?

If you would like any further information please do not hesitate to contact Hayley Peacock (see above).

Thank you for taking the time to read this information sheet.

Appendix 3: Consent form (Phase 1 and 2)

Research Study: Alcohol and Commissioning.
Chief Investigator: Hayley Alderson

Consent to participate in Interviews

Please tick box

I confirm that I have read and understood the information sheet dated 23rd November 2009 (Version 1) for the above study. I have had the opportunity to consider the information, ask questions, and have had these answered satisfactorily.

I understand that my participation in this study is entirely voluntary and that I am free to withdraw at any time, without giving reason and without my legal rights being affected. I understand that if I withdraw, that information already collected with my consent will be retained and used in the study.

I understand that the confidentiality of the information collected will be maintained, it will be stored securely in locked university offices and computer files will be password protected.

I understand that all discussions are confidential.

I understand that, during the course of the study, should any unprofessional, or unethical, or unsafe practices be identified, the researcher has a duty to inform the relevant authorities.

I consent to the use of audio taping, with the possible use of anonymous direct quotes in the study report.

I have read and understood the information and I agree to take part in this study.

Name of participant:.....Date.....Signature.....

Name of Researcher:.....Date.....Signature.....

When completed: 1 copy for participant; 1 copy for researcher.

Appendix 4: Consent form (Phase 3)

Research Study: Alcohol and Commissioning.
Chief Investigator: Hayley Alderson

Consent to participate in Interviews

Please tick box

I confirm that I have read and understood the information sheet dated 23rd November 2009 (Version 1) for the above study. I have had the opportunity to consider the information, ask questions, and have had these answered satisfactorily.

I understand that my participation in this study is entirely voluntary and that I am free to withdraw at any time, without giving reason and without my legal rights being affected. I understand that if I withdraw, that information already collected with my consent will be retained and used in the study.

I understand that the confidentiality of the information collected will be maintained, it will be stored securely in locked university offices and computer files will be password protected.

I understand that all discussions are confidential.

I understand that, during the course of the study, should any unprofessional, or unethical, or unsafe practices be identified, the researcher has a duty to inform the relevant authorities.

I consent to the use of audio taping, with the possible use of anonymous direct quotes in the study report.

I have read and understood the information and I agree to take part in this study.

Name of participant:.....Date.....Signature.....

Name of Researcher:.....Date.....Signature.....

When completed: 1 copy for participant; 1 copy for researcher.

Appendix 5: Topic Guide for commissioners (Phase 1)

Research Study: Alcohol and Commissioning.

Chief Investigator: Hayley Alderson

Introduction

Reiterate issues of confidentiality and anonymity, the purpose of the study and what is going to happen to the data.

Ask interviewees to read and sign the consent form.

Information on role

Can we begin by you providing me with a brief description of your position and role within the NHS?

- Length of time in post?
- how has commissioning changed?

World Class Commissioning

- Understanding of the term World Class Commissioning?
- How many competencies apply to the commissioning of alcohol treatment? (Provide a list of the 11 competencies to prompt discussion)
- Impact of WCC upon the commissioning of alcohol treatment interventions

Commissioning process

Please can you describe the commissioning process in this PCT?

- Who is involved in commissioning decisions?
- Process of monitoring and performance management of decisions?
- Commissioning of voluntary/statutory agencies.

Alcohol Treatment

Can you provide me with an overview of alcohol treatment interventions currently commissioned within the SOTW?

- Needs Assessment
- Is alcohol treatment responding to identified needs?
- Gaps in service provision
- Future plans for developing new innovative services?

Service Users

What role do alcohol treatment providers and service users have in shaping services?

- Monitoring of service user satisfaction

Close

Are there any other points that you would like to add?

Thank respondent. Offer reassurance that all responses will be anonymised and the participant will not be identified in the dissemination of results.

Appendix 6: Topic guide for service providers (phase 1)

Research Study: Alcohol Treatment and Commissioning.

Chief Investigator: Hayley Alderson

Introduction

Reiterate issues of confidentiality and anonymity, the purpose of the study and what is going to happen to the data.

Ask interviewees to read and sign the consent form.

Information on role/agency

Can we begin by you providing me with a brief description of your positions and role within the agency?

- treatment options are available within the agency?
- main focus drugs or alcohol?
- alcohol specific interventions?

Partnership working

What is your understanding of multidisciplinary/partnership working?

- importance of partnership working?
- Duplication of work between alcohol treatment providers?

Commissioning

How much influence do you have with regards to the commissioning decisions made in relation to the treatment interventions available within this agency?

- WCC Competency 2: Work collaboratively with community partners to commission services that optimise health gains and reductions in health inequality- Does this occur?

Service Users:

How is user satisfaction monitored?

- is alcohol treatment responding to identified needs?
- Gaps in service provision
- How could services be improved (this service and/or others)

Close

Are there any other points that you would like to add?

Thank respondents. Offer reassurance that all responses will be anonymised and that participants will not be identified in the dissemination of results.

Appendix 7: Topic guide for general practitioners (phase 1)

Research Study: Alcohol Treatment and Commissioning.

Chief Investigator: Hayley Alderson

Introduction

Reiterate issues of confidentiality and anonymity, the purpose of the study and what is going to happen to the data.

Ask interviewees to read and sign the consent form

Information on role

Can we begin by you providing me with a brief outline of the length of time you have been a general practitioner and your experience of providing alcohol interventions?

Alcohol Knowledge

-Categories of drinker

- (IBA) Alcohol Identification and brief advice- value/obstacles

Screening Tools

-Training

-When would they be used?

-Competency?

-Prevention or treatment?

Alcohol Services

-Knowledge of available services- available treatment options

-Other Primary Care Services (A&E)

-Referral pathways

-Locality of services

-Waiting times

PCT

-How would you describe your relationship with the PCT?

-Do you feel involved in the service formation/commissioning decisions?

-What would you like the PCT to provide with regards to alcohol?

-Impact of white paper on GP commissioning?

Future

-What would improve your experience of providing alcohol treatment interventions?

-Are there any other point that you would like to add?

Close

Thank respondents. Offer reassurance that all responses will be anonymised and that participants will not be identified in the dissemination of results.

Appendix 8: topic guide for service users (phase 1)

Research Study: Alcohol Treatment and Commissioning.

Chief Investigator: Hayley Alderson

Introduction

Reiterate issues of confidentiality and anonymity, the purpose of the study and what is going to happen to the data.

Ask interviewees to read and sign the consent form

Ground Rules

Opening round

-Name, length of time in treatment, 1 word to describe alcohol services.

Experience of treatment

-Can we begin by you giving me a brief outline of you experience in treatment services?

-Did the service meet your needs?

-what was/is good about your experience?

- What would you have liked to have been different?

Comfort Break

Commissioning

- What is your understanding of commissioning?

- Do you feel involved in shaping the available alcohol services?

- Do you feel there is enough Service user involvement?

- What mechanisms of user involvement have you taken part in?

Closing round

Name and check that everyone is ok to leave the group.

Close

Thank respondents. Offer reassurance that all responses will be anonymised and that participants will not be identified in the dissemination of results.

Appendix 9: Topic guide for Commissioners (Phase 2)

Research Study: Alcohol and Commissioning.

Chief Investigator: Hayley Alderson

Introduction

Reiterate issues of confidentiality and anonymity, the purpose of the study and what is going to happen to the data.

Ask interviewees to read and sign the consent form.

PCT preliminary findings report

Impact of organisational changes

- WCC abolished/PCTs phased out- GP commissioning consortia
- SOTW merger- back to locality commissioning
- Alcohol commissioning officer- Staying healthy agenda

Alcohol

- Review of needs assessment?
- Are targets being met?
- Impact of the investment, what could have been done different?

Close

Are there any other points that you would like to add?

Thank respondent. Offer reassurance that all responses will be anonymised and the participant will not be identified in the dissemination of results.

Appendix 10: Topic Guide for Stakeholders (Phase 3)

Research Study: Alcohol and Commissioning

Chief Investigator: Hayley Alderson

Introduction

Reiterate issues of confidentiality and anonymity, the purpose of the study and what is going to happen to the data.

Ask interviewees to read and sign the consent form.

Information on role

Can we begin by you providing me with a brief description of your current position and role?

- Length of time in post?
- How has commissioning changed in the time you've been in your role?
- How has commissioning changed since the Health and Social Act 2012?

Commissioning process

- Please can you describe your current understanding/experience of the commissioning process?
- What is your understanding of the concept of stakeholders – and (in the case of alcohol service commissioning) who do you think they are (or should be)?
- Do you think stakeholders have a good knowledge of what commissioning is?
 - Do you think specific knowledge about commissioning processes is necessary to contribute to discussions about service developments?
- What do you think stakeholders can bring to the table in discussions about service commissioning?
 - Do you think this input is generally heard/accepted/acted upon?
 - If yes, in what way – specific examples
 - If no, why do you think this is the case
- What opportunities do you think exist in your local area for stakeholders to become involved in the commissioning process?
- What do you think are possible barriers/challenges to achieving successful stakeholder involvement in commissioning?
- How do you think different stakeholders feel about being involved in commissioning?

Stakeholders

- How are stakeholders recruited and what methods of engagement are used? (How would they alter depending on stakeholder group- Professionals, Members of the public, Service users?)
- As a stakeholder how much influence do you feel YOU have had regarding commissioning decisions made in relation to alcohol interventions across SOTW?
- How influential do you think stakeholder involvement has had on the design and delivery of alcohol services?

- In your experience what level of participation do you think stakeholders generally have South of Tyne? (Arnstein's ladder)

Alcohol Treatment

- Can you provide me with a brief overview of alcohol interventions currently commissioned within the SOTW?
- What informs/shapes your decisions regarding alcohol commissioning?
- Do you think there are currently any gaps in alcohol service provision?
- Do you know of any future plans for developing new innovative alcohol services?
 - Do you have any ideas about the direction that future developments should take?

Close

Are there any other points that you would like to add?

Thank respondent. Offer reassurance that all responses will be anonymised and the participant will not be identified in the dissemination of results.

Appendix 11: Transcription guide

A standard template was used which displayed the interview body text indented to the right, allowing for a clear separation between the speaker names and the interview text.

Strict verbatim transcription was used with every word being transcribed exactly as spoken some stutters removed.

Lines of transcription were numbered.

Interviewer = **I**

Respondent = **R**

Each transcription was set out as follows;

Unique identifier: ID30

Duration of the recording: 00:53:00

Date of transcription 01/01/2014

End of transcription

References

Abelson, J. e. a. (2004). "Will it make a difference if i show up and share: A citizens perspective on improving public involvement processes for health system decision making." Journal of health service research and policy9(4): 205.

Acheson, D. (1988). Public health in England. London, HMSO.

ACMD (2013). What recovery outcomes doe the evidence tell us we can expect? London, ACMD.

Addicted Britain (2006). The State of the Nation, Addicted Britain.

Alakeson, V. and B. Rumbold (2013). Personal health budgets: challenges for commisioners and policy-makers. London, Nuffield Trust.

Alborz, A. and K. Smith (2002). "Are primary care groups and trusts consulting local communities?" Health & Social Care in the Community10(1): 20-27.

Alcohol Concern (2009). Future Proof: can we afford the cost of drinking too much? London, Alcohol Concern.

Alcohol Concern (2009). The Price is right- Protecting communities through action on alcohol sales. London, Alcohol Concern.

Allott, P. and P. Holmes (1993). Involving service users. In: Community Metnal Health Care (eds Dean, C and Freeman, H). London, Gaskell Royal College of Psychiatrists.

Anderson, P. and B. Baumberg (2006). Alcohol in Europe. A public health perspective. London, Institute of Alcohol Studies.

Appleby J (2013). Spending on health and social care over the next 50 years. London, Kings Fund.

Arah O (2009). "On the relationship between individual and population health." Medicine, Health care and Philosophy**12**(3): 235-244.

Arksey, H. and P. Knight (1999). Interviewing for social scientists. London, Sage.

Arnstein, S. (1969). American Institute of Planners**35**(4): 216-224.

Arnstein, S. (1969). "A ladder of citizen participation." Journal of the American Institute of Planners**35**(4): 216-224.

Auckland, S. (2010). Recruiting and retaining people for user involvement in research. London, National Institute for health research.

Audit Commission (1996). What the Dr ordered: A study of GP fundholders in England and Wales. T. a. commission. London.

Baggott, R. (1990). Alcohol, Politics and Social Policy. Aldershot, Avebury.

Baggott, R. (1998). Health and healthcare in Britain. London, Routledge.

Balance (2012). "People in specialist treatment for alcohol NDTMS quarter 2 update." from <http://www.nepho.org.uk/ndtms/alcohol>.

Barbour, R. (2007). Doing Focus Groups. London, Sage Publications.

Barker, I. and E. Peck (1987). Power in strange places: user empowerment in mental health services: Good practice in Mental Health. London.

Basch, C. (1987). "Focus group interview: an underutilized research technique for improving theory and practice in health education." Health Education Quarterly**14**(4): 411-448.

Bate, A. (2008). Managing Scarcity: Understanding and developing the use of economics in healthcare commissioning. Institute of Health and Society. Newcastle Newcastle University. **PhD**.

Bates, A. (2008). Managing scarcity: Understanding and developing the use of economics in healthcare commissioning. Newcastle, Newcatle University. **PhD**.

Beresford, P. (2000). "Service Users knowledges and social work theory: Conflict or collaboration." British Journal of Social Work**30**: 489-503.

Beresford, P. (2005). "Service user Involvement- regressive or liberatory terminology?" Disability and Society**20**(4): 469-477.

Bloor, M. e. a. (2001). Focus Groups in Social Research. London, Sage Publications.

Boeije, H. (2010). Analysis in Qualitative Research. London, Sage.

Bond, J. and S. Bond (1994). Sociology and Health Care. An introduction for nurses and other health care professionals. Edinburgh, Churchill Livingstone.

Bonner, A. and G. Tolhurst (2002). "Insider-outsider perspectives of participant observation." Nurse Researcher**9**(4): 7-19.

Borg, M. e. a. (2009). User Involvement in community mental health services- principles and practice.

Bowling, A. (1992). "Setting priorities in health: the Oregon experiment (part 1)." Nursing standards**6**(36): 29-32.

Bowling, A. (2002). Research Methods in Health: Investigating Health and Health Services. Buckingham, Open University Press.

Boyce, T. e. a. (2010). A pro-active approach. Health Promotion and ill health prevention. London, The Kings Fund.

Braybrooke, D. and C. Lindblom (1963). A strategy of decision: Policy evaluations as a social process. New york, Free Press.

Brereton, L. and V. Vasoodaven (2009). The impact of the NHS market: An overview of the literature. London, CIVITAS.

British Medical Association (2012). Consultant involvement in commissioning- the implications of the Health and Social Care Act. London, BMA.

Bruni R, et al. (2008). "Public engagement in setting priorities in health care." Canadian Medical Association Journal **179**(1): 15-18.

Bryant, A. and C. Charmaz (2007). Sage Handbook of Grounded Theory. London, Sage.

Bunce, D. (2005). "Fumbling towards democracy." Drink and Drugs News(4): 8.

Burnes, B. (2009). "Reflections: ethics and organisational change- time for a return to lewinian values." Journal of Change Management **9**(4): 359-381.

Burns, D. e. a. (1994). The politics of decentralisation. London, Macmillan.

By, R. (2005). "Organisational change management: A critical review." Journal of Change Management **5**(4): 369-380.

Cabinet Office (2004). Alcohol Harm Reduction Strategy for England. London, Cabinet Office.

Callaghan, G. and G. Wistow (2006). "Publics, Patients, Citizens, Consumers? Power and decision making in primary healthcare." Public Administration Review **84**(3): 583-601.

Cassell, C. and G. Symon (1994). Qualitative methods in organisational research: A practical guide. London, Sage.

Centre for social justice (2007). "Volume 4- Addictions: Towards Recovery." Retrieved 11.10.2011, from <https://www.centreforsocialjustice.org.uk/client/downloads/addictions.pdf>.

Centre for social justice (2013). No Quick Fix: Exposing the depth of Britain's drug and alcohol problem. London, Centre for Social Justice.

Charles, C. and S. DeMaio (1993). "Lay Participation in Health Care Decision Making: A Conceptual Framework." Journal of Health Politics Policy and Law**18**(4): 881-904.

Charmaz, C. (1995). "Between positivism and postmodernism: Implications for method." Studies in symbolic interaction**17**: 43-72.

Charmaz, K. (2006). Constructing Grounded Theory: A practical guide through Qualitative Analysis. London, Sage.

Chisholm, A., et al. (2007). Patient and public involvement in commissioning: A survey of Primary Care Trusts. Oxford, Picker Institute Europe.

Clarke, L. (1994). The essence of Change. Harlow, England, Prentice Hall.

Clarkson, B. (1995). "A stakeholder framework for analyzing and evaluating corporate social performance." Academy of management Review**20**(1): 92-117.

Cluzeau, F. e. a. (2012). "Stakeholder Involvement." Proc Am Thorac Soci**9**(5): 269-273.

Collins, C., et al. (2000). "NHS reform in the United Kingdom and learning from developing countries." Journal of management in medicine**14**(2): 87-99.

Commission, A. (2008). *Is the Treatment Working? Progress with the NHS system reform programme*. London.

Corbin, J. and A. Strauss (2008). Basics of Qualitative Research. London, Sage.

Cornelissen, J. (2008). Corporate communication: A guide to theory and practice. Los Angeles, Sage.

Coulter, A. (2006). Engaging patients in their healthcare: How is the UK doing relative to other countries?. Oxford, Picker institute.

Coulter, A. (2006). Patient Engagement: why is it important. Health Democracy: The future of involvement in health and social care. E. Andersson, J. Tritter and R. Wilson. London, NHS National Centre for Involvement: 27-37.

Coulter, A. (2012). *Leadership for patient engagement* London, The kings Fund.

Coulter, A. and A. Collins (2011). Making shared decision making a reality. London, The Kings Fund.

Cowton, C. and J. Drake (1999). "Went fundholding, Going commissioning? Some Evidence based reflections on the prospects for primary care groups." Public money and management(April-June).

Craig, N. e. a. (2002). "Factors affecting teh shift towards a 'primary care led' NHS: A qualitative study." British Journal of General Practice: 895-900.

Crawford, M. e. a. (2002). "Systematic review of involving patients in the planning and development of health care." BMJ**325**.

Crawford, M. e. a. (2003). *User involvement in change management: A review of the literature*. London, NCCSDO.

Croft, S. and P. Beresford (1992). "The politics of participation." Critical social policy**12**: 20-44.

Curry, N. e. a. (2008). Practice based commissioning: reinvigorate, replace or abandon? K. Fund. London.

Da Silva, D. (2012). Helping people share decision making. London, The Health Foundation.

Darlington, Y. and D. Scott (2002). Qualitative Research in practice: Stories from the field. Buckingham, OUP.

Davies, M. (2007). Doing a successful research project: using qualitative or quantitative methods. Hampshire, Palgrave.

De Vos P et al (2009). "Health through people's empowerment: A rights-based approach to participation." Health and Human Rights Journal**11**(1).

Dentzer S (2013). "RX for the 'blockbuster drug' or patient engagement." Health Affairs**32**: 202.

Department of Health (1989). Working for Patients. London.

Department of Health (1992). The Health of the Nation: A strategy for health in England. London, DH.

Department of Health (1997). The new NHS: Modern, Dependable. London.

Department of Health (2004a). Choosing Health: Making Healthy Choices Easier. London, DH.

Department of Health (2004b). Practice based commissioning: engaging practices in commissioning. DH. London.

Department of Health (2005c). Alcohol Misuse Interventions: Guidance on developing a local programme of development. London, DH.

Department of Health (2005d). Alcohol Needs Assessment Research Project (ANARP). London, DH.

Department of Health (2006b). Our health, Our care, Our Say: A new direction for community services- A brief guide. London.

Department of Health (2006c). Models of Care for alcohol misusers (MOCAM). London, DH.

Department of Health (2007c). World Class Commissioning: Vision Summary. London, DH.

Department of Health (2007d). Commissioning framework for health and wellbeing. DH. London.

Department of Health (2007e). World Class Commissioning Competencies. London, DH.

Department of Health (2009a). "commissioning definition." from <http://www.dh.gov.uk/en/Managingyourorganisation/commissioning/index.htm>.

Department of Health (2009b). Understanding what matters: A guide to using patient feedback to transform services. London.

Department of Health (2010a). Equity and Excellence: Liberating the NHS. London.

Department of Health (2012a). "Long term conditions compendium of information 3rd edition." 2014, from <http://www.dh.gov/publications>.

Department of Health (2012b). The NHS Outcome framework 2013/14. London, DH.

Department of Health (2012c). "Introduction to Personal Health Budgets." 2014, from www.personalhealthbudgets.dh.gov.uk/topics/toolkits/intro.

Department of Health (2012e). The power of information: putting all of us in control of the health and care information we need. London, DH.

Department of Health (2013). Guide to the healthcare system in England. Including the statement of NHS Accountability. London, Department of Health and NHS Constitution.

Department of Health, et al. (2007g). Safe. Sensible. Social. The next steps in the National Alcohol Strategy: 100.

Dowling, B. (2000). GPs and purchasing in the NHS: The internal market and beyond. Aldershot.

Dudzile, S. e. a. (2006). Alcohol and Health in North East England, NEPHO.

Dunphy, D. and D. Stace (1993). "The strategic management of corporate change." Human Relations**45**(8): 917-918.

Edwards A (2009). Shared decision making in health care: Achieving evidence-based patient choice. Oxford, Oxford university press.

Eisenhardt, K. and C. Bougeois (1988). "Politics of strategic decision makin in high velocity environments: towards a mid range theory." Academy of management Review**31**(4): 737-770.

Eisenhardt, K. and M. Zbaracki (1992). "Strategic Decision Making." Strategic management journal**13**: 17-37.

Elliott, E. and G. Williams (2008). "Developing public sociology through health impact assessment." Sociology of Health and Illness**30**: 1101-1116.

English, D., et al. (1995). The Quantification of Drug-caused Morbidity and Mortality in Australia 1995. Canberra, Commonwealth Department of Human Services and Health.

Entwistle, V. and Hanley B (2006). Involving the public. In Pencheon, D et al (eds) Oxford handbook of public health. Oxford, Oxford University Press.

Epstein R and Street R (2011). "Shared mind: Communications, decision making and autonomy in serious illness." Annals of family medicine**9**(5): 454-461.

Feingold, E. (1977). Citizen participation: A review of the issues. cited in Rosen, HM; Mersch, JM and Levey, S (eds) The consumer and the health care system: Social and management perspectives. New York, Spectrum.

Felton, A. and T. Stickley (2004). "Padagogy, power and service user involvment." Journal of Psychiatric and Mental Health nursing**11**: 89-98.

Flinterman, C. e. a. (2005). "The experiential knowledge of patients: A new resource for biomedical research." Social Science and Medicine**60**(11): 2575-2584.

Florin, D. and J. Dixon (2004). "Public Involvement in health care." BMJ**328**: 159-161.

Foucault (1972). The archaeology of knowledge. London Routledge.

French, J. and B. Raven (1960). The Bases of Social Power. Group Dynamics. C. D and Z. A. New York, Harper and Row.

Fudge, E. a. a. (2008). "Assessing the promise of user involvment in health service development: An ethnographic study." BMJ**336**: 313-317.

Fuller, R. and A. Petch (1995). Practitioner research: Reflexive social worker. Birmingham, Open university Press.

Garvin D (1994). "Building a Learning Organisation." Harvard Business Review July/August: 78-91.

Gaventa J and Cornwall A (2008). Power and knowledge. Sage handbook of action research: Participative inquiry and practice Reason P and Bradbury H. New York, Sage Publications. **2nd ed.**

Gibson, A. e. a. (2012). "Theoretical directions for an emancipatory concept of patient and public involvement." Health Affairs **16**(5): 531- 547.

Gomm, R. (2004). Social Research methodology: A critical introduction. Hampshire, Palgrave Macmillan.

Gomm, R., et al. (2000). Case study methods. London, Sage.

Goodwin, N., et al. (1998). "Evaluation of Total purchasing pilots in England and Scotland and implications for primary care groups in England: personal interviews and analysis of routine data." BMJ **317**: 256-259.

Grant, B. and L. Giddings (2002). "Making sense of methodologies: A paradigm framework for the novice researcher." Contemporary nursing **13**(1): 10-28.

Griffiths, J., et al. (2007). Stakeholder Involvement. Geneva, WHO.

Grundy, T. (1993). Managing strategic change. London, Kogan Page.

Guba, E. and Y. Lincoln (1994). Competing Paradigms in Qualitative Research. Handbook of Qualitative Research. K. Denzin and Y. Lincoln. Thousand Oaks, CA, Sage: 105-117.

Guy K and Gibbons C (2003). "Doing it by yourself." Nursing management **10**(6): 19-23.

Ham, C. (1999). Health policy in Britain. Hampshire, Palgrave.

Ham, C. (2007). When politics and markets collide: reforming the English National Health service. HMSC. Birmingham.

Ham, C. (2008). "World class commissioning: a health policy chimera." Journal of health service research and policy**13**(2): 116-121.

Hamel, J. e. a. (1993). Case study methods. Newbury Park, Sage.

Hammersley, M. and P. Atkinson (1995). Ethnography Principles in Practice. London, Routledge.

Hansen, T. e. a. (2004). "The user perspective: respected or rejected in mental health care?" Journal of Psychiatric and Mental Health nursing**11**: 292-297.

Harris, T. (2002). Applied organizational communication: principles and pragmatics for future practice. London, Lawrence Elbaum Associates inc.

Hart, C. (1997). Do people want power? The social responsibilities of empowering communities. Contested communities. P. Hoggart. Bristol, Policy press: 292-297.

Health Committee (2007). Patient and public involvement in the NHS: 3rd Report. H. committee. London.

Healthcare Commission (2008). Is the Treatment Working? Progress with the NHS system reform programme. London, Healthcare Commission.

Healy, M. and C. Perry (2000). "Comprehensive criteria to judge validity and reliability of qualitative research within the realism paradigm." Qualitative Market Research**3**(3): 118-126.

Heath, S. (2014). Local authorities' public health responsibilities (England), House of Commons Library.

Heifetz R, et al. (2009). "Leadership in a (permanent crisis)." Harvard Business Review(July).

Henwood, K. and N. Pidgeon (1994). "Grounded theory: A resource for reflexive and deconstructive analysis? ." Journal of Community and Applied Social Psychology.

Heron, C. and F. Campbell (2010). Practice based commissioning in the NHS: A guide for overview and scrutiny committees. C. f. p. scrutiny. London.

Hickey, G. and C. Kipping (1998). "Exploring the concept of user involvement in mental health through a participation continuum." Journal of clinical nursing**7**: 83-88.

HM Government (2012). The Government's Alcohol Strategy. London, HM Government.

HM Government (2010). Drug Strategy 2010. Reducing demand, Restricting supply, Building recovery: Supporting people to live a drug free life. London, HM Government.

Hoggart, P. (2004). Enough is Enough: Contested communities- Experiences, struggles, policies. Bristol, The policy press.

Horrocks, J. e. a. (2010). Does strategic involvement of service users in the planning, design and commissioning of mental health services lead to better outcomes?

House of Commons Health Committee (2009). Alcohol. London.

House of Commons Health Committee (2010). Alcohol: First Report of Session 2009-10. London The Stationery Office Limited.

House of commons health committee (2010). Commissioning. TSO. London.

Howe A, et al. (2012). Sessional GPs in commissioning. London, RCGP.

Hubbard, C. e. a. (2004). "Users or losers: does the rhetoric of user involvment deliver?" Research policy and planning**22**(1): 53-56.

Huber, G. (1991). "Organisational Learning: the contribution process and the literatures." Organisation Science**2**(1): 88-115.

Hutt, P. and S. Guilmour (2010). Tackling inequalities in general practice. London The Kings Fund.

Iles, V. and K. Sutherland (2001). Organisational Change: A review of healthcare, managers, professionals and researchers. London, NCCSDO.

Irvine, R. (2000). Consuming health- the commodification of Health care. S. a. P. A. e. Henderson. New York, Routledge.

Irvine, R. and J. Stansbury (2004). "Citizen Participation in decision making: is it worth the effort?" Public Administration Review**64**(1): 55-65.

Jarvis, P. (1998). The practitioner- Researcher: Developing theory from practice. San Francisco, Jossey-Bass.

Jeffery, N. (2009). Stakeholder Engagement: A road map to meaningful engagement. Cranfield University, Doughty Centre.

Jick, T. (1995). "Accelerating change for competative advantage." Organisational Dynamics**14**(1): 77-82.

Johnson, R. (1997). "Examining the validity structure of qualitative research." Education**118**(2): 282- 292.

Jones IR, et al. (2004). "Is patient involvement possible when decisions involve scarce resources? A qualitative study of decision-making in primary care." Soc Sci Med**59**: 93-102.

Kaim B (2013). Who are we to care? Exploring the relationship between participation, knowledge and power in health systems. Zimbabwe, TARSC.

Kaner, E., et al. (2007). Brief interventions for excessive drinkers in primary health care settings, Cochrane Database of Systematic Reviews. **Issue 2**.

Kearley K, et al. (2001). "An exploration of the value of the personal doctor patient relationship in general practice." British Journal of General Practice**51**: 712-718.

Kemp, P. (2010). Mental Health, Service user involvement and recovery. London, Jessica Kingsley Publishers.

King, A. (2011). "Service users involvement in methadone maintenance programmes: The philosophy, the ideal and the reality." Drug Education, Prevention and Policy**18**: 276-284.

Kingry, M., et al. (1990). "Focus groups: a research technique for nursing." Nursing Research**39**(2): 124-125.

Kitzinger, J. (1996). Introducing focus groups. Qualitative Research in Health Care. N. a. P. Mays, C. London, BMJ Publishing Group: 36-45.

Klein, R. (1998). "Why Britain is reorganising the National Health Service- Yet again." Health Affairs: 111-125.

Kruger, R. (1994). Focus Groups: A Practical Guide for Applied Research. London, Sage.

Kuper, A. e. a. (2008). "Critically appraising Qualitative research." British medical journal**337**: 687-689.

Kvale, S. and S. Brinkmann (2009). Learning the Craft of Qualitative research interviewing. London, Sage.

Lacobucci, G. (2013). "Conflicting concerns: Doctor's interests and the New NHS." British medical journal**346**.

Lancaster, J. (1999). Nursing issues in Leading and Managign change. Missouri, Mosby Inc.

Layder, D. (1998). Sociological practice: linking theory and social research. London, Sage Publications.

Le Grand, J. (2002). "Further tales from the British NHS." Health Affairs**21**(3): 116-128.

Le Grand, J., et al. (1998). Learning from the NHS Internal Market: A review of the evidence. London.

Lederman, L. (1990). "Assessing educational effectiveness: the focus group interview as a technique for data collection." Communic Education**38**: 117-127.

Lewis, R. (2004). Practice-led commissioning: Harnessing the power of the primary care frontline. K. Fund. London.

Lewis, R. and L. Hinton (2008). "Citizen and staff involvement in health service decision making: Have national health service foundation trusts in England given stakeholders a louder voice?" Journal of health service research and policy**13**(1): 19-25.

Lewis, R., et al. (2009). "From quasi-market to market in the National Health Service in England: what does this mean for the purchasing of health services?" Journal of Health Service Policy**14**(1): 44-51.

Lim, S., et al. (2012). "A comparative risk assessment of burden of disease and injury attributable to 67 risk factors and risk factor clusters in 21 regions, 1990-2010: a systematic analysis for the Global Burden of Disease Study 2010." The Lancet**380**: 2224-2260.

Lindow, V. (1991). "Experts, lies and stereotypes." The health service journal: 18-19.

Lingard, L. e. a. (2008). "Grounded theory, mixed methods and action research." British medical journal**337**: 459-461.

Lipsky, M. (1980). Street-level Bureaucracy: Dilemmas of the individual in public services. New York, Russell Sage Foundation.

Litva, A. e. a. (2002). "The public is too subjective: public involvement at different levels of health-care decision making." Social Science and Medicine**54**: 1825-1837.

Lock, C. e. a. (2002). "A qualitative study of nurses' attitudes and practices regarding brief - alcohol intervention in primary health care." Journal of advanced nursing**39**(4): 333-342.

Lock, C. e. a. (2009). A survey of GP's knowledge, attitude and practice regarding the prevention and management of alcohol related problems: an update of a WHO survey 10 years on. Newcastle, Newcastle University.

Lukes S (1974). Power: A radical view. London, Macmillan.

Luoma-atio, V. and M. Vos (2010). "Towards a more dynamic stakeholder model: acknowledging multiple issue arenas." Corporate communications: An international Journal**15**(3): 315-331.

Lupton, C. e. a. (1998). Managing public involvement in healthcare purchasing. Buckingham, OUP.

Mahmud A (2009). "Doctor-patient relationship." Pulse**3**(1): 12-14.

Mannion, R. (2005). Practice based commissioning: A summary of the evidence. H. P. matters. York.

Martin, G. (2009). "Whose health, whose care, whose say? Some comments on public involvement in the new NHS commissioning arrangement." Critical Public Health**19**(1): 123-132.

Martin, S. and A. Boaz (2000). "Public participation and citizen centred local government: lessons from the best value and better government for older people pilot programmes." Public money and management**20**(2): 47-54.

Mason, J. (2002). Qualitative Researching. London, Sage Publications.

Maxwell, M. e. a. (1993). "General practice fundholding: observations on prescribing patterns and costs using the defined daily dose method." BMJ**307**: 1190-1194.

Mays, N. P., C. (2000). "Qualitative research in health care: Assessing quality in qualitative research." BMJ**320**(7226): 50-52.

McCabe, C. (2004). "Nurse-patient communication: an exploration of patients' experiences." Journal of clinical nursing**13**: 41-49.

McCafferty, S. e. a. (2012). "Implementing world class commissioning competencies." Journal for Health Service Research and Policy**17**(Suppl 1): 40-48.

McCambridge, J. (2012). "A user's guide to the 2012 Alcohol Strategy for England and Wales: A commentary on the commentaries." Drugs: Education, Prevention & Policy**19**(5): 377-378.

McCrae, M. e. a. (2002). Patient and public involvement in health care: A review of the literature. Unpublished paper, Edinburgh University.

McGhee, G., et al. (2007). "Grounded theory research: literature reviewing and reflexivity." Journal of advanced nursing**60**(3): 334-342.

McGraw-Hill (2002). Social Drinker. Concise dictionary of modern medicine, McGraw- Hill companies Inc.

McKinstry B (2000). "Do patients wish to be involved in decision making in the consultation? ." BMJ**321**: 867-871.

McMurray, R. (2007). "Our reforms, Our partnerships, Same problems: The chronic case of the English NHS." Public money and management**27**: 77-82.

Miles, R. and Huberman (1994). Qualitative data analysis: An expanded source book. Thousand Oaks, Sage.

Mitchell, R., et al. (1997). "Toward a theory of stakeholder identification and salience: Defining the principle of who and what really counts." The Academy of management review**22**(4): 853-886.

Mitton C at al (2009). "Public participation in health care priority setting: A scoping review." Health Policy**91**: 219-228.

Morgan, D. (1998). Focus Group Guidebook. London, Sage Publications.

Morgan, D. e. a. (2013). "Introducing Dyadic interviews as a method for collecting qualitative data." Qualitative Health Research**23**(9): 1276- 1284.

Morgan, G. and L. Smircich (1980). "The case for qualitative research." Academy of management Review**5**(4): 491-500.

Morone, J. (1990). The democratic wish: population participation and the limits of American government. New York, Basics.

Morse, J. and L. Richards (2002). Read me first for a users guide to qualitative methods. Thousand Oaks, Sage.

Mullen, P. and P. Spurgeon (2000). Priority setting and the public. Oxon, Radcliff medical press.

NAO (2008). Reducing Alcohol Harm: Health Service in England for alcohol misuse. London, NAO.

NAO (2008). Reducing Alcohol Harm: Health Services in England for alcohol misuse. London, NAO.

Newman P (2012). Sustainable GP leadership: Building foundations for the future. NHS Midlands and East, NHS.

NHS Choices website (2012). "Binge drinking." 2012, from <http://www.nhs.uk/Livewell/alcohol/Pages/Bingedrinking.aspx>.

NHS Commissioning Board (2012). Developing commissioning support. London, NHS Commissioning Board.

NHS Confederation (2010). Too much of the hard stuff: what alcohol costs the NHS. London, The NHS Confederation in association with the Royal College of Physicians.

NHS Confederation (2010). "World class commissioning Assurance results 2009-2010." Retrieved november 2010, from www.nhsconfed.org.

NHS Confederation (2013). Reflections on a decade of NHS commissioning. London, NHS Confederation.

NHS England (2013a). Direct commissioning assurance framework. London, NHS England.

NHS England (2013b). Everyone counts: Planning for patients 2014/15 to 2018/19. Leeds, NHS England.

NHS England (2013c). Transforming participation in Health and Care. London, NHS England.

NHS England (2014). Understanding the new NHS: A guide for everyone working and training within the NHS. London, NHS England.

NHS Institute for Innovation and Improvement (2008). "Stakeholder Analysis." 2009, from <http://www.institute.nhs.uk>.

NHS Institute for Innovation and Improvement (2011). The rough guide to experience and engagement for GP Consortia. London, NHS Institute for Innovation and Improvement.

NICE (2010). "Alcohol-use disorders - preventing the development of hazardous and harmful drinking." from <http://guidancenice.org.uk/PH24>.

NICE (2010). Alcohol use disorders: diagnosis and clinical management of alcohol related physical complications. London, NICE.

NICE (2011). Alcohol use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence. London, NICE.

Nilsen, E. e. a. (2006). Methods of consumer involvement in developing healthcare policy and research: clinical practice guidelines and patient information material (review), Cochrane database of systematic reviews. **issue 3**.

North Tyneside Strategic Partnership (2008). North Tyneside Alcohol Harm Reduction Strategy and Action Plan 2008- 2011. North Tyneside.

NTA (2002). Models of care for the Treatment of drug misusers. N. T. Agency. London.

NTA (2013). JSNA support pack for commissioners of recovery in communities 2013. London, NTA.

Nuffield Trust (2010). Giving GPs budgets fro commissioning: what needs to be done? N. trust. London.

Nuffield Trust (2013). New Structure of the NHS in England. London Nuffield Trust.

O'Connor AM, et al. (2003). "A Survey of the Decision-Making Needs of Canadians Faced with Complex Health Decisions." Health Expectations6: 1-13.

O'Donnell, A., et al. (2014). "From Efficacy to effectiveness and beyond: what next for brief interventions in primary care?" Frontiers in Psychiatry5: 1-8

O'Leary, Z. (2010). The essential guide to doing your research project. London, Sage.

Office for National Statistics (2013). Alcohol related deaths in the United Kingdom, 2011. Newport, ONS.

Oswald, M. and D. Cox (2011). Making difficult choices: Ethical commissioning guidance to general practitioners. London, Royal College of General Practitioners.

Oxford Dictionaries. "Tokenism." February 2014, from www.oxforddictionary.com.

Parahoo, K. (2006). Nursing Research: Principles, Process and Issues. Hampshire, Palgrave Macmillan.

Parsons, S. e. a. (2010). The quality of patient engagement and involvement in primary care. K. Fund. London.

Patrick CH (1952). Alcohol, Culture and Society. Durham. North Carolina, Duke University Press.

Patterson, S. e. a. (2009). Service user involvement in drug treatment services in England.

Patterson, S. e. a. (2009). "User involvement in efforts to improve the quality of drug misuse services in England: A national survey." Drugs, Education, Prevention and policy16(4): 364-377.

Patton, M. (1990). Qualitative evaluation and research methods. California, Sage.

Patton, M. (2002). "Two decades of developments in Qualitative inquiry: A personal, experiential perspective." Qualitative Social Work1(3): 261-283.

Perkins (2001). "What constitutes success? The relative priority of service users and clinicians views of mental health services." British Journal of psychiatry**179**: 9-10.

Peskett, S. (2009). "The challenges of Commissioning Healthcare: A discussion paper." International Journal of Health planning and management**24**: 95-112.

Peters, B. and J. Pierre (2007). Handbook of Public Administration. London, Sage Publication.

Pfeffer, J. (1997). New directions in organizational theory. New York, Oxford university press.

Pilgram, D. and L. Waldron (1998). "User involvement in mental health service development: how far can it go?" Journal of mental health**7**: 95-104.

Plunkett, M. (2008). User involvement in alcohol services: myth or reality? A literature review. Scotland.

Poikolainen, K., et al. (2007). "Alcohol and the preventive paradox: serious harms and drinking patterns." Addiction**102**(4): 571-578.

Poschl, G. and H. Seitz (2004). "Alcohol and Cancer." Alcohol and Alcoholism**39**(3): 155-165.

Propper, e. a. (2002). "waiting times for hospital admissions: the impact of GP fundholding." Journal of health economics**21**(2): 227-252.

Prowle, M. (2010). The risk of GP Commissioning. P. Finance. London.

Public Health England (2013). Alcohol treatment in England 2012-2013. London, Public Health England.

Punch, F. (1998). Introduction to social research: Qualitative and Quantitative approaches. London, Sage Publication.

Rabinovich, L., et al. (2012). Further study on the affordability of alcoholic beverages in the EU: A focus on excise duty pass-through, on- and off-trade sales, price promotions and statutory regulations. Santa Monica, CA, RAND Corporation.

Raistrick, D., et al. (2006). Review of the effectiveness of treatment for alcohol problems. London, NTA.

Rapley, T., et al. (2006). "Still a difficult business? Negotiating alcohol-related problems in general practice consultations." Social Science and Medicine(63): 2418-2428.

Redden, C. (1999). "Rationing care in the community: engaging citizens in health care decision making." Journal of Health Politics, Policy & Law24(6): 1363-1389.

Redding, D. (2014). Engaging with patients. London, National Voices.

Reeves, C. (2010). "A difficult negotiation: fieldwork relations with gatekeepers." Qualitative Research10(3): 315-331.

Rehm, J., et al. (2009). "Global burden of disease and injury and economic cost attributable to alcohol use and alcohol-use disorders." The Lancet373: 2223-2233.

Rehm, J., et al. (2003;). "The relationship of average volume of alcohol consumption and patterns of drinking to burden of disease-an overview." Addiction98: 1209-1228.

Rehm J, R. M. (2013). "Reduction of drinking in problem drinkers and all cause mortality." Alcohol and Alcoholism48(4): 509-513.

Rehm, J. and M. Roerecke (2013). "Reduction of drinking in problem drinkers and all-cause mortality." Alcohol and Alcoholism48(4): 509-513.

Richardson, F. (2006). "The commissioning context." 2013, from www.cat.csip.org.uk/commissioningebook.

Ridley, J. and L. Jones (2002). User and public involvement in health services: A literature review. Edinburgh.

Rimal, R. and M. Lapinski (2009). Why health communication is important in Public Health, Bulletin World Health Organisaion.

Rivett, G. (2010). "National Health Service history." Retrieved January 2010, from www.nhshistory.net.

Robertson, R. e. a. (2014). CCGs one year on: member engagement and primary care development. London, The Kings Fund and Nuffield Trust.

Robinson, R. (1996). "The impact of the NHS reforms 1991-1995: A review of research evidence." Journal of Public Health medicine**18**(3): 337-342.

Rohman, M. (1972). The Cybenetic revolution. New York, Franklin watts.

Room, R., et al. (2005). "Alcohol and Public Health." The Lancet**365**: 529- 530.

Rose, D. e. a. (2003). "Partnership, co-ordination of care and the place of user involvement." Journal of mental health**12**: 59-70.

Rose, D. e. a. (2010). "Perceptions of user involvement: a user led study." International journal of Psychiatry**56**.

Rossow, I. and A. Romelsjo (2006). "The extent of the 'prevention paradox' in alcohol problems as a function of population drinking patterns." Addiction**101**(1): 84-90.

Rowe, R. and M. Shepherd (2002). "Public participation in the new NHS: no closer to citizen control?" Social Policy and Administration**36**(3): 275-290.

Royal college of Physicians (1991). Alcohol and the Public Health: Prevention of harm related to the use of alcohol. London, Macmillan.

Royal Society for Public Health (2014). The RSPH guide to commissioning for health improvement. London, RSPH.

Rubin, H. and I. Rubin (1995). Qualitative Interviewing: The art of hearing data. London, Sage.

Rudman, M. (1996). "User involvement in mental health nursing practice: rhetoric or reality." Journal of Psychiatric and Mental Health nursing**3**: 385-390.

Russ, T. (2008). "Communicating change: A review and critical analysis of programmatic and participatory implementation approaches." Journal of Change Management**8**(3-4): 199- 211.

Rutter, e. a. (2004). "Patients or partners? Case studies of user involvement in planning and delivery of adult services in two recently formed London mental health trusts." Social Science and Medicine**58**: 1973-1984.

Sabey A and Hardy H (2013). "Prepared for commissioning? A qualitative study into the views of recently qualified GPs." Education for primary care**24**: 314-320.

Safer Gateshead (2010). Gateshead Alcohol Harm Reduction Strategy 2010-1012. South Tyneside, South Tyneside Partnership.

Schulte, S. e. a. (2007). "User involvement and desired service developments in drug treatment: service user and provider views." Drugs, Education, Prevention and policy**14**: 277-287.

Seaman P and Ikegwuonu T (2010). Drinking to belong - Understanding young adults' alcohol use within social networks. York, Joseph Rowntree Foundation.

Secretary of State for Health (1999). Saving lives: our healthier nation. London, The stationary Office.

Shapiro, J. (2009). Practice based commissioning: not what it says on the tin. London.

Shenker, D., et al. (2009). All party parliamentary group on alcohol misuse- The future of alcohol treatment services. London, Alcohol Concern.

Singer, M. (1995). "Community participation in health care decision making: is it feasible?" Canadian Medical Association Journal**153**: 421-425.

Skelcher, C. (1993). "Involvement and empowerment in local services." Public money and management**13**: 13-20.

Smith, J. e. a. (2004). A review of the effectiveness of primary care led commissioning and its place in the NHS. T. H. Foundation. London.

Smith, K. e. a. (2009). "Partners in health? A systematic review of the impact of organizational partnerships on public health outcomes in England between 1997 and 2008." Journal of Public Health: 1- 12.

Sobanja, M. (2009). What is World Class Commissioning?

Social Care Institute for Excellence (2013). Coproduction in Social care: what it is and how to do it. London, SCIE.

Sommer, B. and R. Sommer (1997). A practical guide to behavioural research: tools and techniques. Oxford, Oxford university press.

South Tyneside Alcohol Harm Reduction Strategy Group (2007). South Tyneside Alcohol Harm Reduction Strategy 2007-2011. South Tyneside.

South Tyneside Partnership (2013). South Tyneside Alcohol strategy 2013-2016. South Tyneside, South Tyneside Partnership.

Stake, R. (1995). The art of case study research. Thousand Oaks, Sage.

Stein, E. (1995). "Organisational memory: review of concepts and recommendations for management." International Journal of information management**15**(1): 17-32.

Stevenson, F. e. a. (2004). "A systematic review of the research on communication between patients and health care professionals about medicines." Health Expect **7**(3): 235-245.

Stigglebout, A. e. a. (2012). "Shared decision- making: Really putting patients at the centre of healthcare." BMJ,**344**.

Stoker, G. (2006). "Public Value management: A new narrative for networked Governance? ." American review of Public Administration**36**: 41-57.

Sunderland Partnership (2008). Safer Sunderland Strategy 2008-2023. Sunderland, Sunderland Partnership.

Swainston, K. and C. Sumerbell (2007). The effectiveness of community engagement approaches and methods for health promotion interventions. Rapid Review phase 3. N. C. c. NICE. Teesside, Teesside university.

Tenbense, T. (2002). "Interpreting public input into priority-setting: the role of mediating institutions." Health Policy**62**: 173-194.

Tenbense T (2010). "Public participation in health policy in high income countries- why, who, what, which and where?" Social Science and Medicine**71**(9): 1537-1540.

Thompson, A. e. a. (2002). Citizen involvement in health care: Meaning, motivations and means. Final report to the Department of Health (England). Edinburgh, University of Edinburgh.

Tritter, J. and A. McCallum (2006). "The snakes and ladders of user involvement: Moving beyond Arnstein." Health Policy**76**(2): 156-168.

Tritter JM et al (2010). Globalisation, markets and healthcare policy: Redrawing the patient as consumer. New York, Routledge.

Truman, C. and P. Raine (2002). "Experience and meaning of user involvement: Some exploration from a community mental health project." Health and Social care in the community**10**(3): 136-143.

TSO (2011). Policing Reform and Social Responsibility Act. London, The Stationery Office.

University of Stirling (2012). Health First: An evidence based alcohol strategy for the UK. Stirling, University of Stirling.

Van Wersch, A. and M. Eccles (2001). "Involvement of consumers in the development of evidence based clinical guidelines: Practical experiences from the North of England evidence based guideline development programme." Journal for quality in health care**10**: 10-16.

Veronesi, G. and K. Keasey (2009). Policy implementation and stakeholder involvement within the National Health Service. Leeds, Leeds University.

Vicsek, L. (2010). "Issues in the analysis of focus groups: Generalisability, quantifiability, treatment of context and quotations." The Qualitative Report**15**(1): 122-141.

Visram, S. (2011). A qualitative exploration of user engagement and health related behaviour change in the NHS Health Trainers initiative. School of Health, Community and Education Studies. Northumbria, Northumbria University. **PhD**.

Wade, E., et al. (2006). Commissioning in the reformed NHS: Policy into Practice. Birmingham, nhs alliance.

Wales centre for health (2009). A practitioners guide to public engagement for public health in Wales. Wales, Wales centre for health.

Wallcroft, J. (2011). The person in health care policy development.

Wang, J. e. a. (2006). "Knowledge sharing and team trustworthiness: its all about social ties." Knowledge management research and practice**4**: 175-186.

Wanless, D. (2004). Securing Good Health for the Whole Population (summary paper). Norwich, HMSO.

Ward, S. (2012). "The Government's Alcohol Strategy: A view from both ends of the world." Drugs: Education, Prevention & Policy**19**(5): 368-369.

Waterworth, S. and K. Luker (1990). "Reluctant collaborators: do patients want to be involved in decisions concerning care?" Journal of advanced nursing**15**: 971-976.

Weitzman, E. and M. Miles (1995). Computer programs for qualitative data analysis. Thousand Oaks: CA, Sage.

Weitzman, E. and T. Nelson (2004). "College Student Binge Drinking and the "Prevention Paradox": Implications for Prevention and Harm Reduction." Journal of drug education**34**(3): 247-265.

Whittemore, R., et al. (2001). "Validity in Qualitative Research." Qualitative Health Research**11**(4): 522-537.

WHO (2004). What are the equity, efficacy, cost containment and choice implications of private health-care funding in western Europe? Copenhagen, WHO.

WHO (2011). "Lexicon of drug and alcohol terms." from http://www.who.int/substance_abuse/terminology/who_lexicon/en/.

WHO (2013). Health Impact Assessment: the determinants of health. Geneva, WHO.

Whynes, D. e. a. (1995). "GP fundholding and the cost of prescribing." Journal of Public Health medicine**17**: 323-329.

Wilcox, D. (1994). Community participation and empowerment: putting theory into practice. York, Joseph Rowntree Foundation.

Wilcox, D. (1999). A to Z of participation. York, Joseph Rowntree Foundation.

Wilkin, D. e. a. (2001). "Tackling organisational change in the new NHS." British medical journal**322**(7300): 1464-1467.

Williams, B. e. a. (2001). "Hierarchical linear models of factors associated with public participation among residents living near the US army's chemical weapons stockpile sites." Journal of environmental planning and management**44**(1): 41-65.

Williams, L., et al. (2010). "Joined up rationing? An analysis of priority setting in Health and Social Care Commissioning." Journal of integrated care**19**(1): 3-11.

Williamson L (2014). "Patient and Citizen participation in health: The need for improved ethical support." American Journal of Bioethics**14**(6): 4-16.

Wilson, D. (1992). A strategy for change. London, Routledge.

Wirrman, E. and C. Carlson (2005). "Public Health leadership in primary care practice in England: Everybody's business?" Critical Public Health**15**(3): 205-217.

Wood, A. (2003). Why Alcohol is Good for Health. London, Alcohol Concern.

Woodin, J. and E. Wade (2007). Towards world class commissioning. HSMC. Birmingham.

World Health Organisation (2007). International Statistical Classification of Diseases and Related Health Problems. 10th Revision. Geneva, World Health Organisation.

World Health Organisation (2009). Global Health Risks: Mortality and burden of disease attributable to selected major risk. Geneva, World Health Organisation.

World Health Organisation (2011.). Global status report on alcohol and health. Geneva, World Health Organisation.

Yin, R. (2009). Case Study Research: Design and Methods. California, Sage Inc.