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Research utilisation and knowledge mobilisation in the commissioning and joint planning of public health interventions to reduce alcohol related harms – a study in the co-creation of knowledge

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Abstract

Background

Considerable resources are spent on research to establish what works to improve the nation’s health. If these findings are used better health outcomes can follow, but we know that they are not always used. In public health, evidence of what works may not ‘fit’ everywhere, making it difficult to know what to do locally. Research suggests that evidence use is a social and dynamic process not a simple application of research findings. It is unclear whether it is easier to get evidence used via a legal contracting process or within unified organisational arrangements with shared responsibilities.

Objective

To work in co-creation with research participants to investigate how research is utilised and knowledge mobilised in the commissioning and planning of public health services to reduce alcohol-related harms.

Design, setting, and participants

Two in-depth, largely qualitative, cross-comparison case studies were undertaken to compare real time research utilisation in commissioning across a purchaser-provider split (England) and in joint planning under unified organisational arrangements (Scotland) to reduce alcohol-related harms. Using an overarching realist approach and working in co-creation, case study partners (stakeholders in the process) picked the topic, and helped interpret the findings. In Scotland, the topic picked was licensing, in England, it was reducing maternal alcohol consumption.

Methods

69 interviews, 2 focus groups, 14 observations of decision-making meetings, 2 local feedback workshops (n=23 and n=15) and one national workshop (n=10) were undertaken. A questionnaire (n=73) using a behaviourally anchored rating scale was issued to test the transferability of the 10 main findings. Given the small numbers care must be taken in interpreting the findings.

Findings
Not all practitioners have the time, skills or interest to work in co-creation but when there was collaboration, much was learned. What counts as evidence includes: professional and tacit knowledge, and anecdotes as well as findings from rigorous research designs. It was difficult to identify evidence in use and decisions were sometimes progressed in informal ways and in places we did get to see. There are few formal evidence entry points. Evidence (prevalence and trends in public health issues) enters the process and are embedded in strategic documents to set priorities, but local data was collected in both sites to provide actionable messages (sometimes replicating the evidence base).

**Conclusions**

Two mid-range theories explain the findings: i) If evidence has *saliency* (relates to here and now as opposed to there and then) and if the message has *immediacy* (short, presented verbally or visual and with emotional appeal) it is more likely to be used in both settings. ii) Other concerns like risk, culture, working with or against other local issues, are considered alongside research evidence. A second mid-range theory explains how the differing tensions pull and compete as feasible and acceptable local solutions are pursued across stakeholders. Answering what works, depends upon answering for whom and where, simultaneously, to find workable (if temporary) ‘blends’. Gaining this agreement across stakeholders appeared more difficult across the purchaser-provider split, because opportunities to interact were curtailed.

**Future work**

Recommendations are made for practice, researchers and educators, and national research funders. Future research investigating: evidence use across the new public health landscape; the worth of researching in co-creation; the elusive nature of commissioning and evidence use (formal and informal entry); and testing of the two mid-range theories is recommended.

**Funding details**

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<th>Full Form</th>
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<tr>
<td>A&amp;E</td>
<td>Accident and Emergency</td>
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<td>ADP</td>
<td>Alcohol and Drug Partnership</td>
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<td>ADPH</td>
<td>Associate Director of Public Health</td>
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<td>AFS</td>
<td>Alcohol Focus Scotland</td>
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<td>AUDIT-C</td>
<td>Alcohol Use Disorders Identification Test Consumption</td>
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<td>BARS</td>
<td>Behaviourally Anchored Rating Scales</td>
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<tr>
<td>CCG</td>
<td>Clinical Commissioning Group</td>
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<tr>
<td>CHP</td>
<td>Community Health Partnership</td>
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<tr>
<td>CH(C)P</td>
<td>Community Health and Social Care Partnership</td>
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<tr>
<td>CIHR</td>
<td>Canadian Institute for Health Research</td>
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<tr>
<td>CSP</td>
<td>Community Safety Partnership</td>
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<tr>
<td>CSU</td>
<td>Commissioning Support Unit</td>
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<tr>
<td>DH</td>
<td>Department of Health</td>
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<tr>
<td>DPH</td>
<td>Director of Public Health</td>
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<tr>
<td>ECHR</td>
<td>European Convention for the Protection of Human Rights</td>
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<td>EH</td>
<td>Environmental Health</td>
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<td>HWB</td>
<td>Health and Wellbeing Board</td>
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<td>HWS</td>
<td>Health and Wellbeing Strategy</td>
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<td>Acronym</td>
<td>Full Form</td>
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<tr>
<td>HB</td>
<td>Health Board (Scotland)</td>
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<td>HES</td>
<td>Hospital Episode Statistics</td>
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<tr>
<td>ILG</td>
<td>Institute for Local Governance</td>
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<td>JP</td>
<td>Joint planning</td>
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<td>JSNA</td>
<td>Joint Strategic Needs Assessment</td>
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<td>KE</td>
<td>Knowledge Exchange</td>
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<td>KM</td>
<td>Knowledge Mobilisation</td>
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<td>Knowledge Translation</td>
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<td>LA</td>
<td>Local Authority</td>
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<td>LB</td>
<td>Licensing Board</td>
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<td>LBPS</td>
<td>Licensing Board Policy Statement</td>
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<td>LGA</td>
<td>Local Government Association</td>
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<td>LLF</td>
<td>Local Licensing Forum</td>
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<td>LO</td>
<td>Licensing Objective</td>
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<td>LPS</td>
<td>Licensing Policy Statement</td>
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<td>LSO</td>
<td>Licensing Standards Officer</td>
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<td>MRS</td>
<td>Market Research Society</td>
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<td>MUP</td>
<td>Minimum Unit Pricing</td>
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<td>NCB</td>
<td>National Commissioning Board</td>
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<td>NDTMS</td>
<td>National Drug Treatment Monitoring System</td>
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<td>Acronym</td>
<td>Definition</td>
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<tr>
<td>NHS</td>
<td>National Health Service</td>
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<td>NICE</td>
<td>National Institute for Health and Care Excellence</td>
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<td>NWPHO</td>
<td>North West Public Health Observatory</td>
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<td>ONS</td>
<td>Office for National Statistics</td>
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<td>Primary Care Trust</td>
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<td>Public Health England</td>
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<td>PHO</td>
<td>Public Health Observatory</td>
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<td>PLH</td>
<td>Personal license holder</td>
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<td>PL</td>
<td>Premises license</td>
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<tr>
<td>PSHE</td>
<td>Personal, Social and Health Education</td>
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<tr>
<td>RCM</td>
<td>Royal College of Midwives</td>
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<tr>
<td>RQs</td>
<td>Research questions</td>
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<td>SFA</td>
<td>Scottish Framework for Alcohol</td>
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<td>SIGN</td>
<td>Scottish Intercollegiate Guidelines Network</td>
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<tr>
<td>SLP</td>
<td>Statement of Licensing Policy</td>
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<tr>
<td>SPHR</td>
<td>School for Public Health Research</td>
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<tr>
<td>SRE</td>
<td>Sex and relationships education</td>
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<tr>
<td>VCS</td>
<td>Voluntary and Community Sector</td>
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<tr>
<td>VONNE</td>
<td>Voluntary Organisations Network North East</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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Full glossary of licensing terms available from MacGregor 2013 (MacGregor A, Sharp C, Mabelis J, Corbett J. An evaluation of the implementation of, and compliance with, the
Scientific Summary

Background

Despite considerable time and resources spent creating the evidence base on effective public health interventions and multiple policy documents calling for its use, research suggests that it takes on average 17 years to get evidence to embed in practice (if at all). In public health, the use of evidence is particularly difficult. The evidence is often patchy, or created in very different settings, not give the exact answers that are needed in a timely way, giving rise to concerns about the local ‘fit’. The evidence base may be seen as driven by powerful groups, with vested interests and not be trusted. Finally, public health issues go across sectors and are often intertwined with political, economic, and socio-cultural factors making it difficult to know where to start addressing them and requiring solutions joined-up across sectors.

Research suggests that evidence use is a social and dynamic process, subject to, and shaped by, multiple contextual factors and differing stakeholder influences rather than any simple adoption of research findings. It is unclear whether it is easier to secure the use of research evidence via a legal contracting process or within unified organisational arrangements with shared responsibilities. In particular we know little about what conditions might make the use of evidence more likely. This project has investigated these issues.

Objective

To work collaboratively with research partners to investigate how research evidence is utilised and wider knowledge mobilised by managers (and others) in the commissioning and planning of public health services to reduce alcohol-related harms.

Design

Two mainly qualitative in-depth multi-method cross-comparison process case studies (in two sites) were undertaken. Research questions: how, when, where and by whom is research utilised and other forms of knowledge mobilised in the commissioning and planning of public health services; what is the perceived impact; what is involved in working collaboratively with research participants to co-create knowledge; what are the individual and organisational factors that support or hinder research use? A realist framework was used to identify the dominant programme theory; and to ask the overarching theoretical questions of ‘what works
where and under what conditions’ by examining the mechanism, context and outcomes combinations.

Sampling

In real time we examined research utilisation across two different managerial mechanisms for achieving change: commissioning over a purchaser-provider split and joint planning across unified organisational arrangements to address alcohol-related harms.

Methods and Data Collection

Fieldwork took place January 2012 to November 2013 against the backdrop of the global financial downturn and significant NHS reforms in England. We worked in co-creation with our case study partners in three ways: our partners picked the case study process; they could take part in both the research process; and data analysis of emergent findings through joint interpretation fora, if they so wished. Our English partners picked ‘reducing maternal alcohol consumption’; and our Scottish partners picked ‘alcohol licensing’ as the case study process. Through purposive sampling we interviewed key stakeholders (69); carried out 2 focus groups; observed 14 decision-making meetings and examined accompanying documentation. To share our findings and to explore how the findings applied elsewhere (transferability); two local and one national workshop were held and a questionnaire with a modified behaviourally anchored rating scale was issued and used to prompt discussion in the national workshop. A small amount of quantitative work was undertaken to contextualise the case study findings, but routine data to assess organisational quality and performance was either not routinely available, had changed over the period in question or and was not recorded reliably.

Findings

In the Scottish site the process of granting licenses is legally regulated. Within the legislation there is a rebuttable presumption that a license will be granted unless evidence proves that this is unadvisable. Being is an ‘over-provided area’ does not count. Evidence can only be requested (pulled) from the five statutory objectors (of which health is one). At the time of data collection, health no longer routinely responded to each request (lack of capacity; mismatch of population data when applied to individual licenses; and previous unsuccessful attempts torn down by legal agents). A story of competing local tensions emerges between focusing on health outcomes, the night-time economy and more widely economic vibrancy
and regeneration. It is a complex situation where focusing on solely reducing alcohol-related harms may remove the possibility of wider health gains.

In the English site the (then) Primary Care Trust commissioned data collection by a market research company to ask local women and midwives their views on acceptable interventions to reduce maternal alcohol consumption. This data collection temporarily stalled when midwives and pregnant women could not be recruited to take part. This revealed a much wider divide between the commissioners and the provider organisation. We were not able to engage with the provider organisation in our efforts to work in co-creation.

The evidence base on the effects of alcohol consumption in pregnancy is not conclusive and guidance issued by various UK bodies is different. Data on the prevalence of the problem (maternal alcohol consumption) is not easily available locally, or nationally. Many participants discussed the challenges of commissioning where the evidence base is weak. The necessity to be persuasive, using research to tell a story, appealing to both ‘evidence and passion’, building relationships and having the support of local champions were felt important. Participants discussed the difficulty of building these relationships across the formal purchaser-provider split and resorting to informal (un-sanctioned) means to build these alliances.

Across both sites several issues emerged in common. Research evidence, local data and statistics are pulled into organisational decision-making at particular evidence-entry points, but these were few. Strategic policy and planning documents (including the Joint Strategic Needs Assessment) are regularly updated and at this time pull in the latest research evidence. Problematic issues, their prevalence and trends over time are highlighted in order to set local priorities. In this important way all action within the organisations that fall out of these is evidence-informed. The evidence base provides a starting place, raises awareness but rarely directly influences action in an instrumental way. To find actionable messages, both sites attempted to agree actions with partners and collect their own local data. In our case sites this data is more influential in shaping commissioning and planning activity than national research findings. In the Scottish site (licensing) this is local statistics on crime and footfall in city centre outlets, in order to gauge how licensing decisions were working. In the English site local data collection (via the market research company) asked women and midwives about their attitudes to various social media campaigns to guide local intervention development. Beyond this, evidence use is largely up to specific commissioners. Local
knowledge, professional expertise, anecdotes and personal testimony are all taken into account to consider the feasibility and acceptability of proposed activity against often politically charged backdrops. Organisations have created roles whereby the incumbent gathers, collates and interprets external information sources, but there does not seem to be any specific requirement to use this provision.

It was difficult to see evidence in use. It was also difficult to see where commissioning and planning decisions were made. It was not in a place, at a time, but evolving and sometimes taking place outside the formal meetings we observed (as informal chats and ad hoc discussions and in email correspondence).

Road-testing the findings: To explore transferability, the 10 main findings on how evidence is identified, weighted and mobilised were used in a questionnaire using a 9 point behaviourally anchored rating scale. With no right-or-wrong answers, or ‘easy solutions’, these 10 findings can be considered ‘wicked problems’. We identified the ways that these issues are typically, if temporarily, resolved in our sites and used these to write behavioural anchors. The wicked issues were: what type of evidence is most useful; what is ‘valid knowledge’; is evidence ready for use; where is the most useful evidence found; how and where is evidence mobilised (and by whom); what are the contextual influences and other factors that compete to shape the decision; why is evidence mobilised? We included an 11th item to gather the views of respondents on co-creating research.

The BARS questionnaire and invitation to the national workshop was issued widely to stakeholders with an interest in alcohol, licensing, and maternity issues including the voluntary and community sector, and by personal invitation to alcohol leads in local authorities and through practitioners’ networks (73 replies). Respondents were mainly public health, local authority and NHS members. The sample is not representative of all parts of the UK, and the modest response rate suggests caution in over-stating the findings, however, in this small sample, NHS members show a strong preference for academic research; Local Authority - Public Health have a stronger preference for practical experience; and Academics believe that national evidence is more useful in decision making - illustrating different views on what counts. A Chi² of goodness-of-fit confirmed that the spread of responses was unlikely to have happened by chance. National workshop: only 10 delegates attended the national workshop, making it difficult to draw conclusions, but following discussion
participants gave their tips for getting evidence used: don’t be a ‘health purist’ but aim to win people over; identify allies, tailor messages; and use actionable messages to tell a story.

Working in co-creation: Our research participants were volunteers. They identified stakeholders (for interview) and brokered access to the decision-making groups to be observed. They actively took part in the joint data interpretation fora (including local workshops) and helped to contextualise the data. They did not however, choose to add any additional research questions, nor take part in data collection, which was viewed as the role of the research team. Each site picked a tricky issue for us to research, perhaps as a way of surfacing difficult local issues that everyone knew, but could not resolve. In this way the research team’s efforts were deployed tactically by the research participants.

Partners expressed surprise at: the length of time it takes for research to begin (applying for funding, contracting, gaining R&D approvals); what co-creation actually involved; and the time commitment needed to work in co-creation. In the Scottish site where we were able to engage all key stakeholders in the co-creation process (under unified organisational arrangements) and facilitate (or accelerate) the development of closer working relationships between them. A new jointly funded post was developed to boost capacity to respond under the public health licensing objection. In the English site (under commissioning across a purchaser-provider split), we were not able to engage all the key players.

Conclusions

Working in co-creation takes time at all stages of the process. Practitioners may not have the time, willingness, interest, or skills to fully take part. All key stakeholders need to be engaged at the start to secure buy-in. Being on site for data collection was insufficient to become ‘insiders’ and build the necessary trusting relationships. Co-creation might work better if researchers were on site for significant periods of time, suiting ethnographic approaches. Co-creation did not guarantee full access to all research data - there were places we did not get to see (the Licensing Board meetings and informal meetings between commissioners and providers), suggesting limits to the extent to which research participants will subject themselves to the research gaze.

The dominant programme theory is: *Research evidence will enable public health functions to be met more easily.* We explored under what condition this works and explain this in a mid-range theory, through two linked socio-cultural mechanisms (Mechanism) - saliency and
immediacy. If the evidence is salient (about here and now as opposed to there and then) and if it has immediacy (presented verbally, visually and emotionally as opposed to in a passive written format) then it is more likely to be used (in both contexts). Where evidence use works depends on ‘what will work’ (Outcome) and requires a consideration of multiple factors in the context: what has been tried before; local fit; traditions, geography, etc. The answer to one part of the puzzle is dependent on the answer to the others, indicative of a complex system. The pull of competing contextual demands (Context) is explained in a second mid-range theory (a visual schema) to illustrate how this shapes the evidence use (Outcome). Gaining this agreement across stakeholders was more difficult across the purchaser-provider split, because negotiated discussions were often curtailed.

Limitations of the study: Quantitative data was not available to support our analysis. In England, there are no national sources that link ‘alcohol consumption’ with ‘pregnancy’, and local sources are self-reports. High level performance indicators have changed over the past five years as have the organisations that carried them out. NHS indicators that do exist cannot be accessed outside the NHS. In Scotland the numbers of licenses granted (or amended) is neither reported consistently, nor collated in one place. As part of our negotiated entry we agreed not to issue a FOI request for local data. Being a qualitative study (looking at in-depth issues in two sites on different topics) made it important to test and share the findings more widely – but these efforts were only partially successful.

**Future Work**

Recommendations are made. For practice: create more evidence entry points by co-opting information scientists, analysts or academics on commissioning groups, creating standing items on commissioning agendas; with an expectation that evidence will be used if possible. Ensure that routine quantitative data capture meets the needs of the new structures.

For researchers: evidence needs to useful as well as rigorous; consider the role of context in mitigating ‘what works’; consider what can be learned from small research companies in identifying actionable messages. For educators: teach influencing and negotiating skills alongside clinical skills to help practitioners with difficult conversations in politically charged and messy practice environments.

For research funders: consider offering a national responsive research service to meet local pressing research need, and allow more funded research time needed in co-creation studies.
Future research needs to focus on: assessing whether the demands of co-creation are ‘worth it’; investigating the unseen places in which commissioning and planning take place (informal spaces) and investigate the demands for different evidence types in these fora; identifying how evidence is used across the new public health landscape; and investigating the rigour and transferability of the mid-range theories to other contexts.

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(2381 words)
Lay Summary

Considerable money and effort is spent on research to establish what works to improve the nation’s health, but we know the findings are not always used. In this study, we co-operated with one case study site in Scotland and one in England, to work together to explore how research evidence is used when public health initiatives are developed; and what other factors are considered.

We carried out 69 interviews, 2 focus groups, 14 observations, 3 workshops and followed the planning and commissioning of one initiative in each site to reduce alcohol-related harm which were picked by our case study partners, who also helped us interpret the findings. The topics picked were: licensing (Scotland) and reducing maternal alcohol consumption (England). We found that research evidence is used in high-level planning documents to identify problems, but that locally collected information is more influential in deciding on what actions to take.

Evidence is more likely to be used if presented visually and verbally, by a trusted person (rather than written) and if it is about the ‘here-and-now’ of the people using it. Other concerns like risk and fit-into local life are all taken into account. The need to consider different factors and find a blend that is likely to work locally is illustrated in a visual theory as competing ‘pulls’. In this study gaining shared agreement was more difficult across a purchaser-provider split (England), than within shared organisational arrangements (Scotland), but the study was small and more research is needed to confirm the findings.

(251 words)
1 Introduction

1.1 What is the problem and why should we care?

Across the world considerable time, effort and money invested in health research is creating a better understanding of effective and efficient health interventions (the evidence base). National and international policy documents clearly reflect the need to use, where possible, the evidence base to inform effective practice (1-5). These policy calls, to ‘close the gap’ between what we know works (the evidence-base), and frontline practice, occur across multiple policy areas as diverse as health, planning and IT development (6-9) attesting to the prevalence, complexity and persistence of this problem. Evidence from the late 1990’s suggests that, on average, it takes 17 years for evidence to shape frontline practice (8) and twelve years on, despite considerable efforts to share research evidence, the same conclusion is reached by different authors (10). The problem is one of wasted resources (money and effort) creating an un-used evidence base, sub-optimal care provision (based on less effective care or poor delivery) and a moral argument that so much time and effort is expended in doing the ‘wrong thing’ to achieve ‘less-than-the-best’ results. This seems to suggest an ideal where research evidence, policy drives and practice align to deliver optimal care, and where practice does reflect a strong evidence-base we know that outcomes can improve (11). However, in practice, this may be simplistic. It is to these issues that this project was addressed.

In Public Health there are specific challenges to research utilisation. The very nature of public health problems is that they are complex multi-faceted, interlinked and difficult to address with simple interventions (12). Solutions may need to address health, social, and political factors, take time and require support from various stakeholders, so making it difficult to establish clear evidence of effectiveness (12). Specific difficulties are threefold.

First, often the evidence base is patchy or not proven and may be contested (13). Key stakeholders may believe that local conditions are counter-indicative {(13-14). Additionally, public health agendas span health, local government, and voluntary organisations with distinct research cultures, governance and procedural processes and different ‘employee’ members. Efforts to join-up public sector services to enhance coherence and co-ordination in
the pursuit of ‘joined-up services’ have proved difficult (15-16). We know that it is still particularly hard to get research information to flow over professional and organisational boundaries (17-20). All this suggests that gaining agreement on priorities and actions may be challenging (14, 20-21).

Second, the evidence base may not address the questions that practitioners, managers and commissioners (given the exact task-in-hand) want answered, when they need answers – here the evidence base appears to be less than useful, untimely and largely irrelevant as Lomas writes:

“Decision makers—the patients, the care providers, the managers, and the policy makers—tend to see research as a product they can purchase from the local knowledge store, but too often it is the wrong size, needs some assembly, is on back order, and comes from last year’s fashion line. (19:130)

Third, a range of contextual factors may suggest that the evidence-base may not be as objective as it is claimed. Culturally, how participants make sense of their activities (22) can inform what counts as evidence (e.g. home births are considered safe in Canada but the USA favours hospital births (23). In this instance it may be financial and legal concerns that define acceptable practice (23), not research evidence. Politically, evidence emerging from research funded by powerful groups (the drug companies; legislative groups), can squeeze-out opportunities to collect competing evidence (24). Conventionally (see typical online sources that offer guidance to practitioners 25), the ‘hierarchy of evidence’ privileges quantitative; statistical RCTs – largely ignoring plentiful observational and narrative data regarding what the public prefer or what is culturally acceptable and might work (26). Furthermore the introduction of evidence-based practice may be seen as an attempt to impose management control on wieldy and costly processes to standardise practice around a politically driven agenda (27) rather than public choice or public need. It is not just practitioners who may feel that research evidence can be abused, researchers may feel that evidence is mis-used or used selectively to support favoured policy positions or practices (28).

The above illustrates that implementing an evidence base and research utilisation is a complex, dynamic process subject to social, contextual and political influence (14, 17, 18, 29) and it becomes clear that services do not fall out of policy directives in any simple, straightforward or automatic way. The research reported here was designed to be sensitive to
these social processes. Two in-depth mainly qualitative case studies were undertaken, working in co-creation with the research participants rather than doing research on them, respecting their situated expertise and mindful of their contexts.

1.2 The contextual backdrop to this project

Two factors inexorably shaped this project as it took place. The proposal was written, funded and empirical data collected at a time of international financial downturn, resultant financial constraints and the dawning of an ‘age of austerity’ in the UK. Alongside this, the reforms to the public sector of April 2013 and the transitional period leading up to this, created churn, instability and uncertainty within services trying to carry out business-as-usual. Some of the difficulties and disquiet surrounding the reforms was contextually ‘swept-up’ with other data and our findings cannot be fully understood without reference to this troubled context. The influence of this context appears throughout the report.

The project was designed to cross-compare research utilisation across policy contexts (commissioning in England vs. joint planning in Scotland) and this remains the case (see chapter 3). However, the parallel decision to design and operationalise this project in co-creation with co-applicants and research participants also left a deep footprint on the findings as they are reported here. In particular, in an effort to research a topic of most pressing need, salience and usefulness to our case study participants (and to secure ’buy-in’), our case study partners picked the topic of the process case study themselves. When each picked a different topic (licensing vs. maternal alcohol consumption), this made little difference to the core conceptual design (investigating evidence use), but substantially impacted on aspects of the proposed work that needed more traditional approaches. The small health economic component of the project was largely neutered, with no like-for-like health issue to compare relative performance on; it became solely reliant (partially as envisaged) on measures of overall organisational performance. However, existing performance measures also changed during the life of the project, making it difficult to tell a longitudinal story around the organisational performance of our case study sites (see section 8.2 – limitations of the study).
1.3 Structure of the report

This report lays out the design, operationalisation, and findings of the project. The first three chapters give the background. Chapter 1 introduces the topic area and its importance; chapter 2 reviews the literature to summarise what we already know about the topic areas including the ‘promise’ of co-creation; and chapter 3 outlines the methodology of the project including the ‘plan’ for co-creation, the five work streams and the methods of data collection and analysis. The next three chapters report on the findings and are interspersed with analysis, comment and discussion. Chapter 4 reports on evidence use in the alcohol licensing process in the Scottish case study site; chapter 5 reports on evidence use in commissioning to reduce harms related to maternal alcohol consumption in pregnancy in the English case study site. Chapter six reports on the findings from the national seminar and the questionnaire issued to explore how the findings from the in-depth case studies play-out elsewhere. The final two chapters discuss the significance and implications of the findings with chapter 7 reflecting on the ‘experience’ of co-creation; and chapter 8 providing a high-level synthesis of ‘what works’ in relation to the dominant programme theory: Research evidence will enable public health functions to be met more easily. We conclude that research evidence is necessary and useful, but that it is only one part of a complex set of considerations.
2. Literature Review

2.1 Preamble

Best, and Hiatt (30) outline three phases through which the conceptualisation regarding what it takes to get-evidence-into-practice has developed: from linear discrete models; through an appreciation of the quintessentially relational nature of the process and on to a growing understanding of it’s largely unpredictable and complex nature. One conceptual framework has not replaced the others, and all three understandings, to a certain extent, co-exist. We begin this short review of the extant literature with a look at the linear model of knowledge translation and its rise to favour in the evidence-based practice movement of the 1990s, using this as a springboard to explore the developing theoretical understanding of the broad area of translational research.

2.2 Methods

We searched academic literature databases: CINAHL: Cumulative Index to Nursing and Allied Health; Cochrane Library; Google Scholar; GoPubMed; Scopus; SSRN: Social Science Research Network; Web of Science using (but not limited to), the following search terms: translational research; knowledge transfer; knowledge translation; knowledge exchange; knowledge exchange and linkage; knowledge integration, evidence-based medicine; evidence-based commissioning; participatory research; action research; co-creation, co-production; complex systems, and complexity linked to health and public health. The search terms “research utilisation and “public health” identified 973 papers. We cross referenced these papers with those identified via other combinations of search terms and 729 papers appeared more than once. We hand searched all 973 titles (and then abstracts if the titles appeared to be relevant) and 393 papers were of some relevance. We also searched for “alcohol” and “licensing”, (availability, affordability, public health and interventions), and “pregnancy”, and “alcohol-related harm” (health care professionals’ attitudes, FAS) linked to public health and interventions. What follows is not a systematic review, nor does it limit itself to one evidence type. It draws upon qualitative studies and grey literature (in particular policy documents, professional guidelines and advice) as well as reporting findings from
quantitative controlled studies to give an overall narrative review reporting on relevant findings. In addition to this search approach we also drew upon the principal investigator’s knowledge of relevant papers, authors and debates in the area to include papers from their personal archives not directly surfaced via the search terms. This is an approach advocated by (31) as more inclusive of cognate conceptual issues and empirical findings in related, but parallel, disciplines.

2.3 Producing and getting evidence used – the linear model (push and pull)

Historically, within Western societies, universities were acknowledged as “the first and foremost knowledge producer” (32). Dissemination followed a top-down approach with the expectation being that, once produced; knowledge was automatically implemented (29, 33-34). Early models of evidence-based medicine (EBM) were based on positivist, quantitative, and biomedical modes of understanding (see discussion in (53 – 36).

This process was seen as largely linear, one-way, rational and unproblematic. The aims and purpose of EBM are articulated well by Dopson et al who argue that EBM:

“…is about creating a culture where practitioners automatically think in an ‘evidence’-based way every time they see a new case, where it becomes instinctive to seek out research evidence and base treatment decisions on that evidence.” (37:317)

So, if EBM and other linear models worked well, it would not simply result in the ‘push’ of evidence into practice by evidence producers but would also result in practitioners’ desire to ‘pull’ evidence into their practice for themselves (38-39). Davies et al (39) conceptualise knowledge transfer as including three activities: knowledge push (from evidence producers to evidence users), knowledge pull (from users) and linkage and exchange (engagement between producers and users) (19, 39). Kerner et al (40) suggest that passive diffusion is generally ineffective in changing practice and that effective dissemination should be a push-pull process whereby those who can adopt innovations want, and are receptive to, them (pull) and there are, at the same time, clear efforts to assist the adopters in implementing the innovation (facilitation and support). Furthermore, they suggest that tacit knowledge based on experience drives pull whilst explicit knowledge from research drives push. Tetroe et al (41) note that ‘push’ involves diffusion and attempts to disseminate information to a broad audience, ‘pull’ focuses on the needs of users and creates an interest and desire for research
results and ‘linkage and exchange’ exchanges knowledge and ideas by building and maintaining relationships through which information and ideas can flow.

It became clear that EBM could not be simply a matter of applying recipes or pre-determined guidelines because their appropriate application required the use of clinical expertise in addition to clinical evidence and was heavily influenced by professional and peer opinion (21). Although, latterly within EBM, it is acknowledged that there is considerable variation in what is considered ‘evidence’ (anecdotes, clinical opinion, qualitative data, etc. (42), and not all evidence is seen as equivalent (37, 43). The dominant view of the capacity of different types of evidence to faithfully tell us about the world is reflected in the ‘hierarchy of evidence’, with randomised control trials (RCTs) at its pinnacle, and more latterly, the meta-synthesis of RCT evidence (see discussion in (44-45). At this point in time research evidence (and in particular research evidence produced through particular methodologies) was considered to present a privileged view of the world and offer a superior take on ‘what works’ regardless of context. These views were not without challenge with others considering that the selection and use of specific methods and research designs was a matter of ‘horse-for courses’, with differing approaches being useful to answer different research questions (45).

2.4 A changing view of evidence

The rise of evidence-based medicine led to calls for such an approach to be adopted in policy and health care management settings (46-47). Others have argued that attempts to translate the principles of EBM into evidence-based policy have misunderstood the policy process. They argue that the policy process is already evidence-based, but that it draws upon a different kind of evidence:

“Policy decisions incorporate evidence as to whether a policy will be implementable in practice, and whether it will be politically acceptable. Any policy which cannot meet these criteria is not worth pursuing, whatever the research evidence says”

(37:325-326)

In policy development, the social, political and economic climates in which organisations operate – and vested economic interests – may also be significant considerations (48).
Sanderson et al (49) highlights that in practice, the complexity and messiness of policy decision-making raises the role that value judgements play, and suggests that researchers should consider adopting a broader perspective on what counts as ‘evidence’ by investigating how ‘valid knowledge’ as well as research evidence inform policy-making (49). In their discussion of the role of evidence in health promotion and public health (49–50) suggest that the complexity of decision-making means that the development and use of evidence is difficult and contentious. Both authors argue that a collaborative approach is needed for gathering and applying evidence, which requires health practitioners and academics to work across sectors.

What is developing is a growing understanding that evidence and other forms of information flow two-way, influenced by context and the prevailing social dynamics within it, and that to fully understand these issues, understanding context becomes important. The literature begins to acknowledge the way that different types of evidence are varyingly and competitively used, with perhaps different stakeholders keen to demonstrate that they have a (politically) better traction on what will actually work in situ. Contandriopoulos et al (51) suggest that whilst, for researchers, it is the internal validity of a process that leads to ‘best evidence’ (i.e. evidence produced through a recognised research process) they question whether this holds the same importance for practitioners. They argue that as evidence users are exposed to diverse forms of information, only some of which has been produced through scientific methods, they are unable to weight information on the basis of internal validity alone. Tacit knowledge, personal values, and experience may carry significant weight (50). Kothari et al suggest that tacit knowledge is widely embedded in the planning of programmes and services in health-related areas (52). In these contexts, practitioners may draw on both personal and professional experiences in the construction of ‘what they know about the world’ (knowledge frameworks) and tacit and professional knowledge may influence practice more than evidence which is based on specific research findings.

Increasingly nuanced views of what constitutes knowledge, evidence, and research utilisation appear where practitioners are no longer considered merely consumers of university produced knowledge [34]. Knowledge produced “in the sterile laboratory of the isolated scientist” (53:S2.2) is no longer considered “real knowledge” (53:S2.2) and academic research, which rarely meets the direct needs of policy and practice (51), is often ignored (30). Tacit knowledge, previous experience and the influence of colleagues however have become
recognised as powerful guiders of action (21, 32, 52, 54-56). Boaz and Ashby (57), argue that to facilitate the development of evidence-based practice and policy a broader conception of research quality, which includes its fitness for purpose rather than just traditional academic measures of quality, is needed. On a more pragmatic level, it has been suggested that commissioners need three types of knowledge: knowledge from research (‘evidence’), knowledge from data analysis (e.g. statistics) and knowledge from clinician and patient experiences (58).

2.5 Specific challenges of getting evidence used in public health

Getting evidence from public health research into decision making and real world practice is not straightforward (33), not the linear process it is sometimes believed to be, and may bring its own challenges (28). This results in part from the diversity of topics, organisations, and environments that form public health (59) and in part because there is little consensus around what constitutes either knowledge or research utilisation in these contexts (51, 60). The issue is further complicated by the increasing range of terms used to describe these processes (51, 61). The terms often used interchangeably with an assumption often implied that everyone understands their meaning to be the same.

These debates attest to the view of evidence (and its use) as not being a simple, identifiable ‘thing’ (a product that is portable), but rather a dynamic process which may vary according to what evidence is being used, by whom, and for what purpose. What counts as evidence on any one occasion may, in fact, be largely ‘worked-up’ in the flow of the setting of its use. What counts as evidence may be what those involved can be persuaded is evidence (proof) on that occasion (62). Research utilisation may not simply be the instrumental, goal orientated action that the linear model suggests, but that all types of evidence may be used tactically, strategically and politically to steer action in certain directions, or stall and silence as well encourage debate, and as ammunition in securing the imposition of the desired actions of a few (63-64).

Traditional interpretations propose that barriers to research utilisation exist because researchers and practitioners occupy differing ‘communities of practice’ (65) each with their own perspectives of knowledge and utilisation (32, 66) where discussion and information sharing flow freely among members but where flow occurs less across community boundaries
Each community works to its own identified timescales and priorities and these may not be well synchronised (19). However, the interlinked, multi-faceted, nature of public health issues themselves, the responsibility for which are shared across sector boundaries may present unique and substantial barriers to evidence use. It can take many years for any health gains to be seen. Decision makers can feel that the timescales they work to are often too short to ‘prove’ the benefits of using research findings (68). More than this, practitioners have reported that longer term planning was required in order to have a positive impact upon the wider determinants of health or to enable broader societal changes, but that this was constrained by the 4 yearly political electoral cycle in which the short-term political and financial cycles were embedded (67). The frequent NHS reorganisations also inhibited long term planning, with high levels of change, inconsistent and disruptive work patterns, a lack of leadership and the loss of tacit knowledge and organisational memory all led to deflected PCT focus and lost momentum in relation to commissioning (68).

Greenhalgh et al (69) suggests that politics, and the way this impacts upon innovation as well as power relations, can be critical for research evidence uptake. It is argued that health is a “political world and while evidence can be brought to the table, there is certainly no guarantee that it will be acted upon.” In light of these multiple social, relational, political and contextual influences on the use of various types of evidence, researchers have been criticised for having an unrealistic view of the importance of research evidence “which is after all just one piece of a rather complicated jigsaw” (70:381). Previously, researchers were also criticised for prioritising publication in peer reviewed journals (20, 28) more relevant to other academics, than engaging users and promoting utilisation (20, 32). Criticism is similarly levied at health professionals where, although practitioner involvement in research is recognised to positively influence utilisation (71), bureaucracy, centrally directed organisational structures and the need to provide services on time and within budget hamper the use of research (14, 28, 39, 70-72) in this way, the contemplative nature of research can be considered “the opposite of action not the antidote for ignorance” (20:129). The general picture is; “one of poorly connected worlds lacking knowledge of (and often respect for) each other” (20:129). We might speculate that the changes introduced by the most recent research excellence framework assessment (REF 2014) to include impact case studies might prompt closer engagement across the two communities.
Although the two communities theory (66) offers some insight into barriers that inhibit research utilisation, its inherent assumption, that researchers and practitioners are homogenous groups, presents an overly simplistic interpretation, especially when applied to public health in several ways. Firstly, within public health, individuals and organisations working in the same fields often come from diverse disciplines and have differing perspectives and values which influence how knowledge is selected and interpreted (51). Similarly, given the increasing diversity, plurality and multiculturalism of contemporary society, (28, 40, 71-74), many of the issues faced within public health, especially those within the inequalities agenda are complex, multi-dimensional and defy the imposition of single or simple solutions. Stakeholders identify different causes of the problems and correspondingly see solutions in different actions. Such ‘wicked problems’ (73-74) are multi-factorial; with any uni-dimensional solutions offering only ever a partial solution (the ‘problem’ simply morphs to re-surface slightly differently elsewhere). For example: if laziness appears to be the cause of unemployment, forcing the idle to take-up work is the solution, alternatively if the lack of locally available jobs is seen to be cause of the problem, relocation may be the solution, or if there are no jobs, then job creation is the preferred solution. No single approach is either fully correct or incorrect, nor will it ‘solve’ unemployment forever. Weber and Khademian (75) suggest that in order to tackle wicked issues such as health inequalities it is necessary to synthesise complex sets of evidence from across different disciplines and methodological divides, and to understand the process and context of interventions, whilst using such syntheses to inform real-world decisions.

Lastly, the notion of flow of evidence across two communities ultimately rests upon the prevailing metaphor of evidence as a ‘thing on a journey’, from evidence creators to evidence users, with the success of the journey being reliant upon the uptake of the evidence in an instrumental way. We have seen from the above that research utilisation is not recipe-following but ‘cooking’ informed by tried and tested techniques and approaches, with mixing and blending drawing upon and working around the issues that the current context provides as a backdrop. We move on to consider the use of research evidence in a different ways.
2.6 Non-instrumental use of research evidence

The Canadian Institute for Health Research (CIHR) argues that all translational research has at its heart the desire to accelerate the rate of change (38). Yet, rather than leading to radical shifts in practice, the impact of evidence is more likely to contribute to a general shift in thinking. This may range from major conceptual shifts or simple low-level awareness-raising. The new understanding created may remain unspoken and used, or become gradually absorbed into familiar practices rather than directly influencing new ways of working (21-22, 28). Ward et al encourage a need for:

“moving away from narrow descriptions of knowledge transfer towards a broader sociological explanation of the process, testing the adequacy of alternative models of knowledge transfer, and refining and testing tools for designing and evaluating interventions.”(61:157).

These new approaches to research and data collection would need to look for more subtle and indirect use of research evidence and the evolution of impact rather than seeking out overnight revolution as ‘proof’ of research utilisation. This, of course, takes time and presents problems in directly attributing cause-and-effect inferences to evidence use, perhaps stretching our understanding of what scientific enquiry is and how to understand and ‘measure’ impact.

Kothari et al (76) suggests that the importance of the end user’s underpinning value base is key to determining utilisation. Within the context of multi-disciplinary working, as is typical within public health, the differing value bases of differing stakeholders may wrestle for credence in relation to a specific issue. A better understanding of the role evidence plays on values would be useful. Contandriopoulos et al (51) state that it is the extent to which any group working around a specific issue has reached consensus regarding the issue problematisation, the importance of the problem and the measurements of success of potential solutions (how well a group works to achieve issue polarisation) that impact upon research utilisation Best and Hiatt (30) write of ‘knowledge integration’, as opposed to research utilisation, suggesting that it is the ability of the new evidence or knowledge to become part of the culture (values and identity) of the users that influence its use. In this way researching how evidence shapes cultures is also important.
2.7 Exchanging knowledge, relational approaches and complexity

The debate has largely moved away from rational, instrumental uses of evidence to a consideration of more subtle effects of evidence as thought-shaping, (re)defining values, shaping cultures by forming collective views on what is important, and how things should be done. Many have noted that interpersonal trust promotes communication (21, 77) whilst repeated communications encourage trust (51). Mitton et al (78) too note that communication, time and timing, context, the quality of relationships and trust can be very important. Greenhalgh et al (69) also identify that meanings can be re-evaluated and reframed and that the decisions to use research evidence should not be viewed in isolation from other factors, and that it is difficult to predict the size, nature and direction of any changes in advance (70, 79). In summary research utilisation may accelerate change, but it may not be possible to identify, in advance (and therefore control), the direction this takes.

Recent literature has emphasised the importance of interactions between researchers and practitioners (76, 80) and there has been an increasing move towards collaborative approaches to knowledge translation and research utilisation. It has been argued that the use of a more participatory approach enables a more nuanced understanding of context, a shared enactment of facilitation and transformative leadership (81).

2.8 Researching in new ways – participatory approaches and the promise of co-creation

Collaborative research (including participatory action research) describes a partnership between researchers and practitioners to undertake research. Partnerships may be based on many forms of involvement and engagement. Each needs time and genuine resource commitments from all involved to succeed (82). Participatory approaches aim to enhance both the credibility and ownership of research, addressing barriers that inhibit utilisation and allowing each party to develop a greater understanding of each other’s world (32, 39, 83-85). To understand the aspirations for co-created research we need to refer to Van de Ven’s definition of engaged scholarship:

“Engaged scholarship is defined as a participatory form of research for obtaining the different perspectives of key stakeholders (researchers, users, clients, sponsors, and
practitioners) in studying complex problems. By involving others and leveraging
their different kinds of knowledge, engaged scholarship can produce knowledge that
is more penetrating and insightful than when scholars or practitioners work alone on
problems” (83:9)

Collaborative research can: enable greater insight into the interpretation of data (34, 83-
87) adding a contextual perspective to findings (86), supporting implementation (14) and
enabling the development of more focused real world research questions (28, 86). Whilst
outwardly appearing to dissolve the barriers of cross boundary working, collaborative
research is not without its challenges. Researchers and practitioners often do approach issues
from differing agendas and bring competing (and complementary) skills to partnerships (87).
Questions have been raised regarding the objectivity and potential bias of collaboratively
generated research and also the viability of investing typically large amounts of time
developing and sustaining partnerships. Despite the challenges and professional and
organisational compromise that is often needed to develop effective collaborative
partnerships (78, 88) researchers and practitioners alike report benefits (53, 83-85). Typically
it is the strength of the partnership, the people involved and the working relationships
developed that are key to determining effectiveness; “the best processes in the world are
unlikely to produce results without the right people to work within (or sometimes around)
them” (53:S2.5). This suggests that successful relational approaches are partially dependent
upon structural mechanisms to facilitate and support engagement. For example the structures
(e.g. strategic partnerships committee structures and their prescribed membership, and the
softer structures such as job-descriptions, roles and reporting channels) can present
opportunities to engage across professional and sectors boundaries, but may not. Even if
these structural opportunities are present, it still takes the agency of those involved to use the
role and access created to engage with, and promote the use of evidence, with sensitivity to
all aspects of the context.

The calls for collaborative working largely assume that practitioners wish to collaborate in
the research process and the creation of evidence. However, whilst research and evaluation
skills are key public health competencies (89), for many practitioners, they are perceived as
additional responsibilities within already constrained professional remits (89) and not
necessarily welcomed. In reality, organisations and individuals tasked with commissioning
often require support to develop capacity and capability to strive to meet such aspirations.
What is needed is not only more accessible and better public health research but commissioners and public health managers able to use the research and skilled in translating it to their local setting (28, 90). In summary, co-creation and other participatory approaches may enhance both research utilisation and evidence creation in multiple ways, but equally they may be as welcome as "your cat bringing you a dead rat" (35).

2.9 Concluding remarks and the focus of this project

Overall, what we know is that knowledge transfer, exchange and research utilisation are embedded social processes encompassing complex, sometimes context-specific interactions (14, 17-18, 51, 61, 77). In a cross-cutting discipline like public health some authors conclude that taking decisions is a balancing act:

“The public health approach is not an exact science but more an art, balancing competing voices in decision-making such as the evidence of efficacy and cost effectiveness of interventions, patient demand, clinician or speciality interests, financial constraints, collaborators’ and other stakeholders’ agendas, quality standards, targets and so forth” (91:e387)

However, as yet we have few studies of how evidence is used to address live issues, in situ, as the action unfolds to provide empirical examples of how the conflicting factors are pragmatically resolved and how the complexity is pragmatically closed down to achieve action in commissioning and planning decisions. As Dobbins et al note that:

“The influence of: key stakeholders, organizational [sic] culture and values, individual decision-making styles, research evidence, and the importance of the decision itself have yet to be comprehensively studied and understood” (92:157)

Whilst many theories and models seek to explain how and why knowledge is or is not utilised (71, 87) gaps still exist (87, 93) and sometimes precious resources are spent on research that is never utilised (61, 94) Innvær et al (71)] suggest that much literature focuses predominantly on instrumental use of evidence whilst Ward et al (61) suggest that how knowledge is actually used is often overlooked in discussions and especially in models of knowledge translation and little exists that identifies specific approaches that make utilisation
more or less likely in particular contexts (61, 78, 93). It was to address these gaps that our research focused. We considered that varying organisational structures (commissioning across a purchaser-provider split versus joint planning) created by differing policy contexts would provide varying managerial mechanisms for mobilising and using evidence and simultaneously affect the relationships between those involved and what could be achieved (agency) (see chapter 3).

We now proceed to give a brief synopsis of the extant literature relating to the substantive topic areas selected by our case study partners: alcohol licensing and alcohol consumption in pregnancy. We begin with a short overview of the area of alcohol-related harms as a public health issue.

2.10 Alcohol misuse – a clinical and public health issue

In 2002, in developed countries, alcohol ranked third after smoking and hypertension as the leading cause of ill-health and premature death (95). A key indicator of alcohol harm in the population is measured by mortality due to liver disease. UK cirrhosis mortality rates have risen sharply over the past thirty years especially in Scotland (104% increase in males, 46% for females). In England and Wales there was a 69% increase in males and 44% for females (96). What makes this rise more poignant is that corresponding figures from the EU, over the same time period, fell by 30% (96).

For some years, UK drinking patterns appear to be out of step with the rest of Europe, where consumption of alcohol has increased by roughly 50% since 1970, compared with France and Italy where consumption has more than halved (97). In particular, the numbers of women who are drinking at harmful levels has increased in some areas of the UK. This has led the Scottish Government (98) to report that alcohol related mortality among Scottish women is now higher than that of English men for the first time. Substantial differences between regions in the UK are noted, with greatest increases in alcohol-related deaths being seen in Glasgow, North East and North West England, including among younger women born in the 70’s, leading to calls for targeted action (99). Differences in patterns of drinking have been noted with older, affluent women tending to drink more frequently than less affluent women (100). The wider health, economic and social effects of increasing alcohol consumption are well documented elsewhere (101, 102) and efforts to reduce the harm caused by alcohol
(103) would result in benefits for women of child bearing age as well as the wider population (104).

At a population level, ‘alcohol problems’ range further than alcohol dependency or alcoholism. Heavy drinking is believed to contribute to many social problems (e.g. anti-social behaviour and crime, domestic violence, drunk-driving, accidental injuries, assault and poor street and environmental cleanliness) (105). Heavy drinkers outnumber people with alcohol dependency by 7:1 (106). Consequently, the greatest impact in reducing alcohol problems can be made by focusing on prevention rather than the treatment of ‘alcoholism’ (the so-called preventive paradox) (107-108) and makes alcohol abuse a mainstream public health issue.

2.10.1 Alcohol Misuse Interventions

In cultures of heavy drinking, the most cost effective approaches to prevention focus on regulating the environment particularly focusing on the price, availability and marketing of alcohol (103, 109). Typically this requires legislative change, however, concerted community based programmes can be effective at reducing alcohol problems in specific areas following similar strategies (110). These approaches may include education and information campaigns, controls on selling and other regulations reducing access to alcohol (supported by surveillance and law enforcement), and led-through community organisation and coalitions. The second most cost-effective strategy is for public sector services (particularly the NHS) to deliver systematic programmes of screening and brief intervention (109). Here, typically, a conversation between a practitioner (typically in Primary Care or A&E settings) and a heavy drinker takes place. Current alcohol use is discussed and future consequences of alcohol misuse explored. There is a large and robust evidence-base supporting brief alcohol interventions (111) and this approach is a key component of alcohol misuse prevention guidance published by NICE (112).

In addition, the Department of Health advises a co-ordinated approach to reducing alcohol related hospital admissions advocating what are called ‘High Impact Changes’ (HICs) (104). The seven HICs have been extensively used across the NHS and local government to highlight practical measures that can be implemented at local level. Three HICs suggest how efforts can be best organised to achieve success: work in partnership; develop activities to
control the impact of alcohol misuse in the community; influence change through advocacy. The remaining four HICs suggest services, interventions and activities that can be commissioned to reduce alcohol-related harm and reduce the rate of the rise in alcohol-related admissions. These four HICs are: improve the effectiveness and capacity of specialist treatment; appoint an Alcohol Health Worker; offer Brief Intervention to provide more help to encourage people to drink less; and amplify national social marketing priorities (104).

2.10.2 Alcohol policy and licensing

Anderson (113) argues that New Labour alcohol policy: framed alcohol-related problems in individual terms; was developed in partnerships with the alcohol industry; ignores the social context of alcohol-related issues or problems; and has increased alcohol-related harm, whereas an effective alcohol policy should flatten trends and reduce harm (113). In England and Wales, the 2003 Licensing Act restricted the power of licensing to “the prevention of crime and disorder, public safety, the prevention of public nuisance, and the prevention of children from harm, and not with public health” (113). The Act did not offer any licensing responsibilities for the behaviour of customers after they had left the licensed premise. Moreover, it stipulated that licensing should not interfere with the free market and its understanding of ‘need’ was attached to the commercial demand for an additional premise (113). In Scotland, the Nicholson Committee report published a review of licensing law in 2003, exploring ways in which licensing legislation could be used to modify drinking cultures and binge drinking in particular. Below, we provide more detail of the Scottish licensing policy context in light of our case study (chapter 4).

Licensing law in Scotland has previously been based on the 1973 Clayson Report and Licensing (Scotland) Act 1976, which had recommended longer opening hours and the option of premises seeking special dispensation for extended hours of opening (114). At the same time, alcohol also became more affordable, with a 54% reduction in real cost between 1980 and 2003 (115) and a 70% change in affordability between 1980 and 2010 (116). The Nicholson Committee recommended the abolition of statutory permitted hours, including those for off-licences and supermarkets, with local licensing boards agreeing opening hours for specific premises and Liquor Licensing Standards Officers supervising and monitoring the system’s operation in each licensing board’s area (114). It was suggested by the
Nicholson Committee that licensing boards would have to introduce policy statements to outline both their expectations and mode of operation. Furthermore, a licensing forum, with a broad membership, would review the licensing board’s activities and highlight any local issues or concerns. These two structures were intended to provide local accountability for the licensing board’s decisions and would sit under a National Licensing Forum headed by the Ministers for Justice and Health which would review practice and advise on problems, with national guidelines for practice and training (114). The range of allowed objections and objectors was narrow, covering nearby residents, local community councils, some officers of the local council, chief constables and health and safety officers (114). Medical and health perspectives were, at that time, potentially absent from this as their staff were not generally included in the permitted objectors.

2.10.3 What ‘works’ in the context?

In the Scottish context it is suggested that a range of measures are effective in alcohol policy, including regulation, early detection and interventions, treatment and support, in addition to education, with controls on price and availability, drink driving legislation and brief interventions being most effective (115-116). Alcohol Brief Interventions are a key element in Scottish alcohol policy, with suggestions that these reduce alcohol consumption for up to a year in harmful or hazardous drinkers, and in 2008 a target was set for a total of ~150,000 interventions by 2011 with each health board achieving an agreed number in line with SIGN guidelines (116). It is suggested that front loading (drinking alcohol at home before going out to a licensed premise) is an increasing trend amongst under 25s and more focus needs to be put on off-sales (115).

The 2005 Licensing (Scotland) Act was based on five licensing objectives: 1) preventing crime and disorder, 2) securing public safety, 3) preventing public nuisance, 4) protecting and improving public health, and 5) protecting children from harm (115). It is interesting that whilst public health is a key objective, the decision-making structures around licensing boards do not incorporate health representation. The updated report (115) reviewed actions relating to protection and controls, prevention and education, provision of services and ‘getting the framework right’. There is also some discussion of the impact of alcohol and of changing alcohol cultures. Within ‘protection and controls’ intended actions are summarised
in relation to licensed premises, actions in the community and action with the UK government. Intended actions in the ‘prevention and education’ category cover those relating to general information and communication, plus those targeted at schools, workplaces and the community. Intended actions relating to ‘provision of services’ are discussed at three levels: nationally, in the community and in primary and secondary care settings. The aims pertaining to ‘getting the framework right’ are discussed in relation to structures, information and evaluation and training.

Further priorities and actions are suggested in the Scottish Government’s 2008 discussion paper (98) and the ensuing framework for action (117). These documents identify targets in relation to the Scottish Government’s three overarching priority themes: ‘improving our productivity and competitiveness’, ‘increasing our labour market participation’ and ‘stimulating population growth’. Alcohol-related actions are outlined in relation to the themes of reduced consumption, supporting families and communities, ‘positive attitudes, positive choices’ and improved support and treatment. Some key actions for consideration in these reports include: modifying the Licensing (Scotland) 2005 Act to end both the option for off-sales premises to supply alcohol free of charge with a purchase (e.g. buy one get one free schemes); ending reduced price sales of alcohol; introducing a minimum price per unit as a condition of both Premise and Occasional Licences; consideration of raising the minimum age for alcohol purchases; applying a Social Responsibility Fee; reviewing test purchasing; improving enforcement; focusing on early intervention through the Community Initiative to Reduce Violence; restricting the display of marketing material and encouraging responsible marketing; working with health and industry partners; introducing mandatory product labelling (ideally as part of a common system across the UK); establishing a working group to update core services for alcohol treatment; supporting the evaluation of brief interventions pilots; supporting NHS boards in reaching brief intervention targets and exploring the opportunities for developing psychological therapies. The issues of minimum pricing and trade discount bans in Scotland are discussed more thoroughly in a University of Sheffield report (118) which offers a detailed conceptual and statistical discussion and models potential scenarios. At the date of writing, the Scottish governments efforts to introduce minimum unit pricing for alcohol, is being challenged in the courts.
2.10.4 European policy on alcohol and licensing

Whilst national policies are probably most significant with regard to approaches to alcohol problems and licensing, there are also intersections with European policy. The European Commission’s 2006 Communication on alcohol used research about the effectiveness of different policy measures pertaining to the reduction of alcohol consumption and harm, and identified five priorities for best practice: 1) protecting young people, children and the unborn child, 2) reducing injuries and deaths from alcohol-related road traffic accidents, 3) preventing alcohol-related harm among adults and reducing the negative impact on the workplace, 4) informing, educating and raising awareness about the impact of harmful or hazardous alcohol consumption and highlighting appropriate consumption patterns, and 5) developing and maintaining a common evidence base at EU level (119). Guidance on advertising has also been set at the European level. It is noted by Gordon and Anderson (119) and Anderson and Gual (120) that the commission places significant emphasis on education, but this is the least effective alcohol policy option. Moreover, the impact of alcohol misuse on mental health and wellbeing has been significantly undervalued (120). Issues such as cross border shopping are also very relevant, and may become more so with the divergence of English and Scottish policies.

Next we provide an overview of what is known about women’s alcohol use in pregnancy and explores some of the key themes identified to support the findings from Rosetown (chapter 5).

2.10.5 Prevalence of alcohol consumption in pregnancy

Firstly, it is difficult to know the size of the problem. According to national surveys, around a third of women in the UK drink more than medically recommended levels (121-122). Estimates of alcohol consumption during pregnancy vary widely, with some national surveys estimating 5% of women drink alcohol during pregnancy (123) compared with 54% in other studies (124). However, estimating the amount of alcohol women drink is complicated and inexact, with considerable variation between research studies and countries (125) and little standardisation about what constitutes heavy, moderate or light use. This results in imprecise definitions and difficulties of interpretation and comparison (126). Poor understanding among the population of units and measures of alcohol (127) may also lead to under
reporting. It has been noted that alcohol use, particularly in pregnancy, remains a socially stigmatised activity and surveys of drinking behaviour in pregnancy may underestimate the true extent of alcohol consumption (128) through fear of social disapproval (129).

A Swedish study found that older age, living in a major city, with low social support and using tobacco during pregnancy, as well as pre-pregnancy drinking, were predictors of women’s drinking in pregnancy (130). It has been suggested that increased awareness of the dangers of drinking in pregnancy has resulted in changes in women’s behaviour (131), but this may simply be women reporting less alcohol consumption.

2.10.6 Effects of light to moderate drinking in pregnancy

Secondly, it is difficult to estimate the harms caused. There is considerable debate about the effects of light to moderate drinking in pregnancy in published literature and media reports (e.g. Taylor 2012). A 2006 systematic review found no robust evidence of poor outcomes amongst women consuming moderate amounts of alcohol whilst pregnant (132) whereas a 2009 review found impaired cognitive and socio-emotional development in children aged 3-16 in three of the six studies reviewed (Swedish National Institute of Public Health (133). Advice to avoid alcohol in pregnancy is recommended following a study of the Danish National Birth Cohort which found a strong graded association between alcohol intake and risk of miscarriage in the first sixteen weeks of pregnancy (134). In Australia, no independent effects of light to moderate drinking were found on birth weight or head circumference at five years. Similarly, a large scale Danish study (1,628 women) found no significant impact of preschool child intelligence. In the UK (Millennium Cohort Study) Kelly et al (135) suggest there is no increased risk of behavioural or cognitive deficits at age 3 for children whose mother drank within recommended limits compared to children whose mothers did not drink. Indeed boys born to light drinking mothers were less likely to have conduct / hyperactivity problems, showing some apparently protective effects of alcohol, with similar findings in Australia (136), although there may be important confounding factors as light alcohol consumption is noted as a marker of relative socio-economic advantage, which can influence children’s social and emotional behaviours. These effects were shown to continue until children reached 5 years of age (137).
Elsewhere it is also argued that the risks are not clearly established, and there is a need to understand possible risk factors mediating the relationship between drinking and outcomes (138). Factors might include: difference in drinking patterns (e.g. frequency, quantity, variability and timing); as well as absolute levels of alcohol exposure in utero (139-140), which have all been shown to affect the functioning of young children. Although the likelihood is that individual differences in alcohol metabolism may protect most women, it is not possible to predict who is at risk. A recent finding from a large population based study found variants in genes involved in alcohol metabolism amongst children and mothers who had drunk in moderation during pregnancy, associated with lower cognitive ability in the children at age eight (141). This suggests, that in some cases, even small amounts of alcohol in utero can affect future cognitive outcomes leading some authors to conclude that we may never be able to conclusively prove whether there are safe levels of alcohol consumption in pregnancy, making it morally and ethically unacceptable to suggest otherwise (140, 142-144); a message at odds with current UK guidelines.

2.10.7 Effects of heavy drinking in pregnancy and Foetal Alcohol Spectrum Disorder (FASD)

We know that FASD is a set of conditions which are poorly understood by the general public and health care professionals limiting opportunities for appropriate diagnosis, prevention, early intervention and treatment (128). Children affected by maternal alcohol consumption suffer a range of primary and secondary disabilities, the effects of which are often seen, although not well understood, by education providers and early years practitioners (127).

Numerous studies have shown the harmful effects associated with heavy drinking in pregnancy (128), with heavy alcohol consumption increasing the risk of low birth weight and preterm birth (145). Experts agree that there is a dose dependent effect of alcohol on foetal and child development (100).

The term Foetal Alcohol Syndrome was first coined in 1973 by Jones and Smith in the US, but as research has accumulated, terms have changed, and remain inconsistent between countries and institutions (146). Foetal Alcohol Spectrum Disorder (FASD) is an umbrella term that covers foetal alcohol syndrome (FAS), alcohol-related neurodevelopmental disorders (ARND), alcohol related birth defects (ARBD), foetal alcohol effects (FAE) and
partial foetal alcohol syndrome (pFAS). Symptoms include: changes in facial appearance; hyperactivity; impulsivity; difficulty with abstract concepts; poor problem solving and social skills; and difficulty learning from consequences (147), leading to developmental, health, behavioural, intellectual, learning, emotional and transition-related difficulties (127). Disabilities range from mild to very serious and affect individuals throughout their life course.

There is currently no reliable UK data on the incidence and prevalence of FASD as routine data are not collected, definitions differ and under reporting is likely (148). Estimates of the economic impact of FASD are acknowledged as scarce with studies limited to the USA and Canada, and calls for a standardised methodology to allow for proper comparisons across countries (126). One study estimated that the cost of FASD annually to Canada of those affected from birth to 53 years old was $5.3 billion, providing a strong rationale for commissioning prevention programmes (146).

2.10.8 Assessment and detection of problem drinking in pregnancy

Thirdly, there is difficulty in knowing where and when to target interventions. Pregnancy is considered to be a ‘teachable moment’, a time of increased motivation to learn and eliminate unhealthy behaviours (including excessive alcohol consumption) (125). Routine screening tools have been developed which are quick, inexpensive, and are shown to be effective at identifying problem drinkers in the pregnant population in Canada (e.g. the AUDIT-C, comprising the first three questions of the full AUDIT tool (149-150). In both Australia and the Netherlands, whilst women found screening acceptable; midwives were reluctant to discuss alcohol with women in their care, felt they needed additional training in asking difficult questions, and in managing those who disclose (151-152). A small scale qualitative study of the factors that influence women’s disclosure of substance use in pregnancy in Australia found that a non-judgemental, rather than confrontational approach encouraged disclosure. Midwives reported a good rapport, and trusting relationship were essential and for women direct questions, continuity of care and addressing child protection issues early and honestly helped (153). The booking visit when women first come into contact with antenatal services has been identified as important, alongside multi-disciplinary collaboration.
and co-ordination of services for pregnant women, who may experience embarrassment and stigma (154).

Alternatively, given that up to half of all pregnancies are reported as unplanned (131), with many women consuming alcohol unaware that they are pregnant, alcohol consumption in the first trimester is likely to be common suggesting that intervening at the first booking midwifery booking appointment may be too late. The latest national alcohol strategy (155) recognises that FASD can be caused by mothers drinking before they know they are pregnant; so preventing them is strongly linked to reducing the levels of heavy drinking in the population as a whole (universal as opposed to targeted interventions). There may be arguments to continue with both universal and targeted interventions. Although many women are known to reduce their alcohol consumption in pregnancy, a sizable minority who continue are thought to drink moderate amounts or binge drink (125). In a systematic review of fourteen international studies, women’s pre-pregnancy alcohol consumption appeared to be consistently associated with drinking during pregnancy, alongside exposure to violence and abuse (156), leading the authors to highlight the importance of antenatal providers assessing these factors to improve detection of women at continuing risk.

2.10.9 International and UK guidelines on alcohol and pregnancy

The official recommendations regarding alcohol consumption in pregnancy differs between countries. The USA and Denmark advise pregnant women to abstain from alcohol. Since 2009, the Australian government has advised women to abstain, moving from guidelines suggesting if they choose to drink, to consume less than seven drinks per week, never more than two drinks on the same day, and never get drunk (157).

In the UK before 2008, the National Institute for Health and Clinical Excellence suggested that pregnant women limit alcohol consumption to no more than one standard unit per day. Currently, pregnant women and women planning a pregnancy are advised to avoid drinking alcohol in the first three months of pregnancy if possible, because it may be associated with an increased risk of miscarriage (112). The guidance goes on to state that, if women choose to drink they should be advised to drink no more than one to two UK units once or twice a week (Note: one unit equals half a pint of ordinary strength lager or beer, or one shot [25 ml] of spirits. One small [125 ml] glass of wine is equal to 1.5 UK units.) National Institute for
Health and Clinical Excellence (112) guidance states that although there is uncertainty regarding a safe level of alcohol consumption in pregnancy, at this low level there is no evidence of harm to the unborn baby (112).

The Department of Health’s guidelines (158) endorse this approach stating that pregnant women or women trying to conceive should preferably avoid drinking alcohol altogether. The recommendations suggest, that if they do drink, women should not exceed the limits outlined above and not get drunk, as getting drunk or binge drinking during pregnancy may be harmful to the unborn baby. A recent review of the evidence base by the UK Chief Medical Officers the Government concluded that ‘current guidance adequately balances the scientific uncertainty with a precautionary approach’ (101). This view is not universally held. NHS Health Scotland (159) and the British Medical Association Board of Science (128), have produced more conservative guidelines, recommending that women who are pregnant, or who are considering a pregnancy, should be advised not to consume any alcohol at all, as there is no known safe level of alcohol consumption in pregnancy.

An RCM guidance paper on alcohol and pregnancy (160:3) recommends that midwives advise pregnant women about the risks of consuming alcohol and to avoid alcohol while pregnant and breastfeeding. The RCM encourages midwives to understand the evidence base, and adopt an individualised approach, which will enable them to discuss the implications of alcohol use. Midwives are expected to support pregnant women who continue to consume alcohol and encourage them to seek further help if abstaining from alcohol is problematic. Overall, evidence on the effects of drinking alcohol in pregnancy is contested and contradictory, resulting in different national and international guidelines. This gives conflicting and somewhat confusing messages to women and the health professionals who provide their care.

2.10.10 A wider understanding of the stigma and shaming of alcohol use in pregnancy

So far, this short literature review has taken a medicalised view of alcohol consumption, largely ignoring the leisure, pleasure and cultural aspects of drinking alcohol, whereas for most people this may be the only aspect of alcohol consumption that makes sense to them. It has allowed us to focus on the research evidence of alcohol-related harms, but it is guilty of treating alcohol in the ways that sometimes ‘food’ is treated in the obesity literature – as a
‘medicine’, without reference to pleasure, comfort and social inclusion that eating bring (161-162). The extant public health literature views alcohol as a toxin and in keeping with this, continuing to drink during pregnancy is considered irrational, illogical and wilful. Unless we open our understandings to see a competing view that culturally links alcohol with sociability, with ‘having a good time’ or with relaxation (its social and cultural significance) then we may miss some of the reasons why many people drink, where they drink, and why women to continue to drink in pregnancy.

A growing body of literature in the social sciences questions the ways in which pregnant women and their foetuses have become such ‘a potent focal point for regulation, monitoring and control’ (163). Concerns have been expressed about the punitive and value-laden language that is used to describe the exposure of foetuses to damaging substances and the moral assumptions which underpin these discourses (164), generating something of a moral panic (165). Drawing on Foucauldian concepts of the neoliberal government of citizens, Lupton (163) notes that pregnant women are encouraged to take ethical responsibility for themselves and their foetus by avoiding exposure to harmful toxins like alcohol and tobacco. Failure to respond to expert advice about appropriate health promoting behaviours in pregnancy risks exposing women to critical public gaze, judgement and recriminations for lack of self-discipline and self-sacrifice (166). Some see policy makers who advocate abstinence without a clear evidence base as creating new definitions of risk, formalising a connection between uncertainty and danger, transforming health advice into rules ‘less connected to a balanced assessment of evidence’ (167). Empirical research in Australia found high levels of guilt and anxiety reported by women about the welfare of their children, with marked social class differences observed (168). Interviewees were aware of the judgemental attitudes of others, including other mothers, towards their efforts to conform to the ideal of the ‘good mother’. These findings are important to note in the context of efforts to raise awareness among women of the risks of drinking in pregnancy, and enable women to access appropriate services in a timely manner. It may also explain why the routinely collected self-reported data on alcohol consumption during pregnancy is viewed as unreliable (and often it is not collected at all).
3 Methodology

3.1 Overview

The study design, research questions and proposal was a collaboration effort (and jointly written) across the research team. Half of the research team members are senior practitioners in the NHS, LA or other national public sector organisations and it was their choice to investigate public health initiatives to address alcohol-related harms. Two in-depth largely qualitative cross-comparison case studies (in two sites) were undertaken. Each process case study was designed to investigate research utilisation in a live, real time process of the commissioning cycle (or joint planning in Scotland) start-to-finish, in relation to services or interventions to reduce alcohol-related harms. With a strong focus on collaborative working and knowledge co-creation, this study draws primarily upon qualitative methods, although a small amount of basic quantitative work was undertaken to help contextualise the qualitative data. To see if the findings were typical and applied elsewhere a 2-stage Delphi questionnaire was designed and issued to interested stakeholders (followed by the wider issue of this questionnaire – see below). A national workshop was held to share and discuss the findings.

The aim, research questions, objectives, data collection methods and fieldwork details are discussed in more detail below starting with the overarching realist framework and the impact that concurrent public sector reforms had on the project, its design and execution.

3.2 Overarching analytical framework

The overarching analytical framework is provided by Pawson and Tilley’s notion of realistic evaluation (that mechanism plus context informs outcomes) – to ask the fundamental question: ‘what works where and under what conditions’ (169).
3.2.1 Programme theories

Behind commissioning (and joint planning) processes are programme theories – that is to say the assumptions (or ideas) about how things work or what the active ingredients are in a process that makes it work. A key task was to identify these programme theories and look at how they played out in different contexts. For example a programme theory may be: ‘supplying research evidence into the commissioning (or JP) process will ensure that research evidence is mobilised in the decision-making process to secure evidence informed commissioning (or JP) decisions’. The realist approach asks under what conditions (where and for whom) does supplying research evidence into the commissioning process secure evidence informed commissioning – where and how does this hold true and why? We were looking for the key components (active ingredients – socio-cultural mechanisms) that made this work, or not. Central to the realist approach is an exploration of the context-mechanism-outcome interactions and this informs the design of this project. Different policy contexts in the UK (English and Scottish health policy) require managers to operate within different managerial mechanisms (commissioning versus joint planning) to secure public health services and interventions. The realist task is to investigate how and in what ways the interplay between context and mechanism influence the use of research (and other types of) evidence - the outcomes, in order to build mid-range theories. These theories in turn may be modified and developed through their application across additional contexts.

Key to understanding the differences will lie in exploring the extent to which different NHS contexts provide varying managerial mechanisms for effecting change. The potentially hard contractual lever of commissioning across a purchaser-provider split (or joint commissioning across the NHS and LAs as is more common for cross-cutting public health issues) is the predominant English managerial mechanism. In Scotland, however, single outcome agreements seek to establish a shared commitment to priorities across partners at the level of each LA (with no purchaser-provider split or commissioning arrangements). A pejorative understanding of the difference may be expressed in this way: England - commissioner’s contract, provider’s work; Scotland - shared work. Within these two contexts, the mechanisms managers have available to them may mediate strongly in what action can, and should, be taken as well as how that can be achieved. Each context may offer different opportunities (barriers and facilitators) for research utilisation allowing events to play-out in different ways.
A look across contexts will permit initial observations of how these things play-out in practice and implications for commissioning approaches. It might allow us to see if forceful commissioning is essential to drive change but potentially damaging to long-term purchaser-provider relationships (or unduly legalistic). We do not know if integrated arrangements ameliorate relational issues by negotiating agreement but are less able to secure radical changes.

### 3.2.2 Conceptually clearing the ground

In line with the realistic approach, it is necessary to ‘conceptually clear the ground’ and to also clarify the wider context of this research. Without wishing to open a complex debate on epistemology, we take a pragmatic approach to defining our terms, throughout the project we use the term ‘evidence’ in its widest sense to mean:

“noun

- the available body of facts or information indicating whether a belief or proposition is true or valid: *the study finds little evidence of overt discrimination*

- *Law* information drawn from personal testimony, a document, or a material object, used to establish facts in a legal investigation or admissible as testimony in a law court: *without evidence, they can’t bring a charge*

- signs or indications of something: *there was no obvious evidence of a break-in*

origin: Middle English: via Old French from Latin *evidentia*, from evident- 'obvious to the eye or mind’” (170).

Within this definition what counts as evidence is diffuse: facts, information, signs, indications, testimony, documents, and material objects may all, in the appropriate context, be considered ‘evidence’ that something is true or valid. We proceeded on the understanding that research utilisation is a socially situated activity – so that what counts as good (useful), knowledge and evidence will depend on the audience and the context – and that this is turn informs how it can be used (or abused?) and to what end. To understand events we locate them within the context that gave them meaning and made them possible. We adopt this
diffuse definition of evidence as it is the one routinely used by our research participants to inexorably shape their understandings of what counts.

However, where useful, we contrast this lay understanding of ‘evidence’ with ‘research evidence’, to explore the issues raised when an externally coded evidence-base, that is widely accepted in rational western society as a privileged way of understanding the world, attempts to trump lay and situated understandings of what counts in a given context. By ‘research evidence’ we mean the available body of facts or information indicating whether a belief or proposition is true or valid as it results from the research process and as analysed through recognised methods i.e.:

“…the systematic investigation into and study of materials and sources in order to establish facts and reach new conclusions:” (170)

To focus the research gaze within the process case studies (and avoid looking too widely at all types of evidence used in all parts of the process), we concentrated on the times and places where overt use was made of research evidence (and other types of knowledge). For other definitions see the Glossary section.

3.2.3 The context - researching in a changing public health landscape

The fieldwork for this project (Jan 2012 – Nov 2013) coincided with the public sector reforms introduced by the Health and Social Care Act 2012. During this period public health commissioning in England moved from the NHS to local authority control. Between 2012 - 2013, public commissioners (i.e. our research participants) were in transitional arrangements and after April 2013 they became LA employees, although some (e.g. the DPH) had already held a joint NHS / LA post since 2007. For much of this time (and in the contracting period before the project officially began) the precise details of the reforms, new organisational structures, funding arrangements including ring-fenced funding for public health services were still being negotiated. It was unclear what public health services and interventions would remain in place post reforms. In addition, the global financial downturn, and the resultant public sector financial constraints introduced by the 2010 UK government, formed a much wider backdrop of uncertainty regarding the nature and longevity of public
health provision, especially given that funding to the NHS was protected whereas LAs have been subject to substantial reductions in funding.

To cope with this level of uncertainty and to take what steps were possible, at that time, to ‘future-proof’ the project to ensure that it was not derailed by as yet unseen changes resulting from the reforms, the research team decided that:

i) The data collection would ‘follow-the-action’ (13) and not study case study sites (i.e. physical entities which were being dissolved) but follow the process of commissioning (or JP) wherever the action that was taking place. In accordance with this, as public health moved to the LA, the project moved with them and carried on.

ii) To ensure that the commissioning process around the intervention or service being tracked would still exist post reforms; a high profile public health issue was identified. It was decided that reducing alcohol-related harms was likely to remain a priority concern regardless of other organisational or political priorities.

These changes were incorporated into the project design and the project protocol. The case studies became process case studies to follow research utilisation (and use of other types of knowledge) in public health commissioning (or JP) to reduce alcohol-related harms.

3.3 Design

A qualitative methodology, to focus on the social and situated process of evidence use and the meanings and significance this holds for participants, was selected. Two interpretive in-depth multi-method cross-comparison process case studies (one in each of two sites) were undertaken (171-172). A qualitative methodology was

3.3.1 Key Aim

To work collaboratively with research participants to explore and understand how research is utilised and knowledge mobilised by NHS and LA managers (and others) in the commissioning and planning of public health services to reduce alcohol-related harms.
As an exercise in the co-creation of knowledge (83) – it is important for us to be able to show *how we worked with* our research participants to achieve our aim. In order to map this out clearly we have added details of the ‘research engagement process’ to the customary study aim, research questions, and key objectives.

### 3.3.2 Research Questions (RQs)

1. How, when, where and by whom is research utilised and other forms of knowledge mobilised in the commissioning and planning of public health services? What is the perceived impact?

2. What is involved in working collaboratively with research participants to co-create knowledge?

3. What are the individual and organisational factors that support or hinder research use in the commissioning and planning of services?

### 3.3.3 Key Objectives

1. To engage research participants in the research process (co-creation of knowledge) (meets RQs 1, 2&3).

2. To track the commissioning process (and joint planning) in public health for research utilisation (meets RQ 1&3).

3. To identify knowledge management roles (and the opportunities and challenges posed by this role) (meets RQ 1&3).

4. To explore individual and organisational learning around research utilisation (embedding and sustaining research utilisation) (meets RQ 1, 2&3)

5. To explore any link between research utilisation and organisational performance (the impact) (meets RQ 1&3).

6. To explore and discuss transferability of the findings (meets RQ 1, 2&3).
3.3.4 Research Engagement process

- To negotiate entry, identify mutual RQs within the research brief and agree the process case study [176] (meets RQ 1, 2&3).

- To engage participants in the research process (e.g. to allow them to contribute to: recruiting research participants; data collection; write-up of results if they so wish) (meets RQ 2).

- To hold bi-monthly (or as otherwise agreed) feedback and joint data interpretation meetings (meets RQ 1, 2&3).

- To engage a wider set of stakeholders in the interpretation of the findings via: local workshops; a modified 2-stage Delphi process; the UK national workshop; and the dissemination of results through professional and policy networks (meets RQ1, 2&3).

3.4 Operationalising the project

3.4.1 A Study Designed to Co-Create Knowledge

In order to ensure at least a minimal degree of collaborative working we required two things from our participating sites:

i) That the sites were keen to take part, and that they picked the specific topic, (the commissioning, or joint planning cycles we were to follow, within the study parameters i.e. to reduce alcohol-related harms). This devolved decision-making was to help ensure: local buy-in; that the research addressed issues that were timely, useful and relevant to services needs and; to show our commitment to work together on areas of mutual interest.

ii) That the sites take part in regular feedback and data review sessions – to encourage joint interpretation of the data, its importance and explore possible iterative responses to it (changing practice). The establishment of a joint interpretation group on each site would
allow collective reflection on the findings in terms of accuracy, completeness and usefulness and identify next steps for the research. These reflections also informed recruitment of respondents and questions for the follow-up interviews.

These two requirements formed the core conditions of co-creation. If, at the point of negotiated entry, our proposed participants were not able to offer to try and meet these, then we would be unable to precede working with that site. In addition to this, beyond these core requirements, we offered our participants the opportunity to add extra research questions and to participate in data collection and report writing, if they so wished. In forming these working patterns we hoped to build strong relational ties with our collaborators permitting a deeper level of trust, and not only leading to better access, (and therefore to richer data), but also to a greater understanding of what it takes to work collaboratively across the academe/practice boundary. An extended period of negotiated entry (four months) was built into the project timescale to accommodate the needs of the co-creation process. Documents explaining the co-creation approach were produced and shared to support the entry process.

Implications of allowing the case study sites to pick the commissioning topic

We anticipated that there would be two main implications of allowing the sites to select their own topic for the case study. Firstly, an initial period of uncertainty i.e. that only after agreeing the specific commissioning/planning process would it become clear who the specific stakeholders were (e.g. for interviews); or what the most appropriate routine datasets to consult for the quantitative impact analysis would be. We had considered that this would be a temporary state – which a carefully negotiated entry process would clarify and help establish the final study parameters.

Secondly, across our case studies we accepted that we would be unlikely to be comparing like-with-like cases in the traditional sense (comparing the same public health intervention). We therefore constructed our sampling strategy to allow comparison not of the topic area, or health outcomes but to contrast the managerial mechanism for enabling the use of evidence.
### 3.4.2 Sampling

The focus of comparison across our two process case studies became an identification of how research evidence (and other types of knowledge) was being used under either commissioning (across a purchaser-provider split) or joint planning across unified organisational arrangements. Therefore, a case study in England (purchaser-provider split) and Scotland (joint planning) were selected. The varying English/Scottish contexts provide a natural experiment across which to sample these differences. Our sampling strategy can be seen in Table 1 below.

<table>
<thead>
<tr>
<th>Context</th>
<th>Case Study Process</th>
<th>Case Study Site</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managerial</td>
<td>Commissioning with purchaser-provider split</td>
<td>English PCT in transitionary arrangements with the local Health and Well-being Board (NB: latterly with the LA).</td>
</tr>
<tr>
<td>Mechanism</td>
<td>Joint planning (no purchaser-provider split, no commissioning)</td>
<td>Scottish Health Board with partners organisations (NB: ultimately within the LA).</td>
</tr>
</tbody>
</table>

**Table 1: The sampling strategy to compare research utilisation in process case studies according to the managerial mechanisms for securing public health services or interventions to reduce alcohol-related harms**

Selection of sites

After careful discussion between the research team and the advisory group both the English and the Scottish site were identified by their similar population profiles (large, post-industrial urban conurbations). Previous nationally funded public health research had been undertaken across these locations, and we sought to add to this evidence base. In both sites the DPH was known to members of the research team and this facilitated the initial approach. The sites themselves were keen to take part.

### 3.4.3 Work streams and methods

Data was gathered through five distinct strands of work. These are listed below (i-v) with the specific methods associated with them.
3.4.3.1 Two in-depth process case studies (172).

One English case study site (Rosetown) with the process case following research utilisation (and use of other types of knowledge) in a commissioning process to address alcohol-related harms. The second process case was undertaken in a Scottish case study site (Thistletown) following research utilisation in a joint planning process across unified organisational arrangements, again, to address alcohol-related harms.

i) In-depth qualitative interviews: with those carrying out the commissioning or joint planning to explore research utilisation; the rationale; opportunities; challenges; and perceived impact of the process at operational, tactical and strategic levels. Repeat interviews (with those directly involved) after milestones events to gather developing views.

Observation of commissioning (or JP) meetings: to observe live (as opposed to reported) research utilisation and the mobilisation of other types of evidence.

Documentary analysis of the written documents that record process activity e.g. minutes; commissioning (JP) agreements; strategic documents.

ii) In-depth qualitative interviews with those holding a knowledge management role within the two case study processes (i.e. those who gather, synthesise and supply evidence into the process) to investigate the opportunities and challenges posed by their roles.

Interviewees were recruited via purposive sampling (those directly involved in the commissioning or JP process under study) and via snowball sampling (additional people identified as active agents in the process by these initial interviewees, including those people holding a knowledge management role). Interviews followed a semi-structured topic guide (see Appendices, 1 and 4) however content was iterative, as both data collection and data analysis took place concurrently and followed the method of constant comparison (173) with data analysis from earlier interviews informing topics discussed within later interviews. In this way the interviews were able to increasingly hone-in-on issues of key interest.

All interviews were digitally-recorded and transcribed verbatim (by an external agency at another location in the UK to preserve anonymity). All identifying details were removed at
the point of transcription. A coded list linking participants to their transcripts was kept so that first interviews could be linked to subsequent interviews. Following transcription digital-recordings were erased. Electronic and hard copies of transcriptions have been retained in accordance with Teesside University ethics committee policies and procedures.


An impact assessment in the strict understanding of the technique was not possible in the timescales of this project, nor was a cross comparison of ‘performance’ on the same public health issue across the sites (except on the broadest level). Our aspiration was to look at measures of overall organisational performance to see if there was any reason for considering that these organisations were typical (or outliers) in what they are able to achieve. Although the data would not establish causal links it might have enabled us to see if the organisations are good, fair or failing to help in the interpretation of the qualitative findings and provide a way of locating the significance of what was found - does its evidence-use show-up in the larger measures? Does it not make any discernible difference? (See chapter 8.)

3.4.3.2 Exploring the transferability of the case study findings – overview.

The design of this study permitted an in-depth, situated and rich account of research use (and other types of evidence) in one commissioning and one joint planning process, at a specific point in time. It was important to understand to what extent the findings from the two case study processes applied in other contexts. As a first step local feedback workshops allowed us to check our interpretation of the findings with local stakeholders. These stakeholders included commissioners in other public health topic areas locally, to see if the findings applied in other areas of commissioning locally. Secondly, a modified Delphi process and an interactive workshop were designed to enable us to ‘road-test’ the findings to explore their relevance to other settings, and gain insight into whether the case study findings were context specific or transferable to other settings. (Note: we detail the aspirations for the Delphi process – but also include details of the steps we took when the response rate to stage one of the Delphi was very low)

iv) A modified 2-stage Delphi process using a BARS questionnaire (see below): 10 of the main findings emerging from the case study processes (that illustrated both
similarities as well as differences across the cases – nomothetic and idiographic data) were selected for inclusion in the Delphi process questionnaire. One other question on co-creation was included. A nine point behaviourally–anchored rating scale (BARS) was used (described in more detail below and in chapter 6, including the modifications to the proposed Delphi process). The first round of the Delphi was issued with the invitation to the national workshop.

v) An interactive dissemination workshop: offered the opportunity to both disseminate and road-test emergent findings and to explore transferability of the findings through discussion and debate. The workshop invited those with an interest in alcohol misuse and related issues – practitioners, managers, commissioners and those from the voluntary sector to attend. Results of round one of the Delphi questionnaire prompted debate to get ‘expert / stakeholder’ comment on the emergent findings. A second round Delphi vote was taken. The data from the modified Delphi and field notes on the workshop, detailing the issues raised in the discussion, are incorporated into the findings of this report. As an additional unforeseen step, (because numbers attending the national workshop were so small), we issued the BARS questionnaire from the Delphi process to a wider national audience to boost the numbers (as a 1-stage process). This allowed us to gather the views on the applicability of the 10 main findings more widely. We analyse this questionnaire (as outlined in the section below), initially as a 2-stage Delphi process (but because the numbers are so small this is only included in the appendices for interest) and a one-stage questionnaire (using exactly the same questionnaire, based on the main 10 emergent findings) to test the applicability of the views more widely. These responses form the bulk of the analysis in chapter 6.

3.4.3.3 Delphi questionnaire design.

A modified Delphi process with a questionnaire using a behaviourally anchored rating scale (BARS) was used to road-test the findings. The Delphi process itself was designed to maximise the input and expertise to a debate without incurring any negative face-to-face group influences (i.e. peer group pressure, minority influence, etc.) (174) A questionnaire is issued to ‘experts’ (often geographically dispersed) for their views, feedback on the results given, least popular answers removed, and a second, and possibly subsequent, questionnaires issued.
BARS are a form of Likert scale, first used in organisational psychology (175-176, 178) typically in instruments designed to standardise descriptions of employee performance appraisal (i.e. what would an ‘excellent’ performance as opposed to a ‘poor’ or ‘average’ performance actually look like). As such they were said to help ‘ground’ the scale in actual (recognisable and meaningful) behavioural descriptors to add clarity, enhance validity and acceptability of the instrument (176-180).

The aim in modifying the BARS questionnaire and in creating the anchors for the questionnaire was, as far as possible, to use the terminology of the respondents and illustrate the choices (dilemmas?) they face in their daily practice as decision makers trying to use evidence. We provided competing behavioural anchors at either end of the scale (that we recognised from our data) to tease out the conflicting pull of each choice across the issue identified in table 10. Where respondents placed their X, represents for them, the resolution between the two competing anchors. Examples of a similar method being used in health care research can be found in (56, 181-183).

Respondents were also asked to indicate on a three-point scale, ranging from not important to very important, how important they thought each pair of statements were. In addition, the following bibliographic data was collected: job title; organisation name; and work location to enable comparison across different groups of respondents (e.g. NHS employees versus LA staff). The instrument was piloted with a small number of researchers for readability and ease of use. (For the full questionnaire, including rubric, see Appendix 7.)

3.4.4 Research Governance, project governance and patient and public involvement

Ethics committee approval was granted by Teesside University. In consultation with the local IRAS committee and in accordance with the GAfREC agreement (184) it was agreed that full IRAS committee approval was not needed, as only professional staff were taking part in the research in line with their professional roles. In Rosetown, R&D approval was gained from six NHS Trusts and in Scotland R&D approval was granted from the host Health Board (HB). No additional research approvals were needed for engagement with the LAs in either of the two case study sites.

Governance for the project was provided by an advisory group consisting of two external academic members; a commissioning lead for alcohol and the public health advisor for voluntary organisations North East network (VONNE). This member was able to provide a
public voice and comment on the project and interim findings from a voluntary and community sector perspective.

3.5 Data collection

3.5.1 The Scottish case study process

3.5.1.1 Co-creation – negotiated entry and selecting the process case study.

Discussions began within Thistletown in mid-2011, initiated by the co-applicants, more than one of whom knew key stakeholders in the site in their professional capacity. An initial face-to-face meeting with the DPH, head of service improvement and head of information services introduced the team and the study (aims, objectives, RQs, etc.) and introduced the notion of co-creation and the opportunity for the site to choose the topic that they wished the research to address (in relation to joint planning for the reduction of alcohol-related harms). The opportunity to be active in the research process and the necessity of establishing the joint interpretation group (or as they called themselves our ‘adoptive family’) was raised. The resulting discussion clarified the nature of the project and stakeholders were left to consider the topic they wished to select. A second meeting (supported by intervening email correspondence and shared documents (e.g. the lay summary, etc.) took place in early 2012. In addition to the original stakeholders, additional people attended representing public health, social care, and the corporate planning office of the LA. At that meeting it was formally decided (with input from the HB, LA and the research team) that the project would focus on research utilisation in the alcohol licensing process. We further reflect on this period of negotiated entry and the choice of case study process in chapter 7.

The time we had spent in establishing relationships with public health staff at the HB, was lengthy, but not wasted, however identifying the new stakeholders, who were involved in the alcohol licensing process took time. Then we began a second period of negotiated entry, this time with the LA. An initial meeting in spring 2012 was set up with representation between the LA’s corporate planning office, the elected member (who served as chair of the local licensing board) and a legal representative of the council. Once again, details of the project, co-creation aspirations, and entry requirements were all shared and discussed. The legal nature of the process and the limitations it created for access to information was clarified.
The PI agreed not to issue a ‘freedom of information’ request to draw down further information in support of the project (beyond the data collected through the data collection process). In consultation with the co-applicants and the advisory group, it was agreed to proceed with this case study process.

3.5.1.2 Fieldwork

Fieldwork began in February 2012 with periodic updating till September 2013. Table 2 identifies the interviewees by role. Table 4 gives an overall summary of all the research activity in both sites.

<table>
<thead>
<tr>
<th>Number of interviewees</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Health</td>
</tr>
<tr>
<td>5</td>
<td>Legal</td>
</tr>
<tr>
<td>9</td>
<td>LA</td>
</tr>
<tr>
<td>8</td>
<td>Other</td>
</tr>
</tbody>
</table>

Table 2: Participants by role in the Scottish case study interviews

3.5.1.3 Observations

Observations were made of the local Licensing Board and local Licensing Forum meetings. As these meetings are open access public meetings, Thistletown (LA) specified that no formal consent was needed from those attending in order for the research team to observe. However, without formal consent, we have not included direct quotations from the meetings, but have elected to use this information to contextualise our findings and aid the interpretation we place on them. The researcher attending meetings kept detailed observation notes and reflections within a research diary.
3.5.1.4 Documentary data.

In Thistletown the research team had access to previous minutes, agendas and documents presented at Licensing Forum meetings and Licensing Board meeting documents – all of which are publicly available on the council website. The team also had access to Thistletown Licensing Board Policy statement (2010; full reference withheld) and overprovision statement (2010; full reference withheld) and as presented within Licensing Forum meetings the draft Licensing Board Policy statement (2013) and draft Overprovision statement (2013; full reference withheld) presented during pre-consultation.

3.5.2 The English case study process

3.5.2.1 Co-creation – negotiated entry and selecting the process topic.

Initial discussion began with Rosetown in Dec 2011, following email introductions. Two on-site meetings with the DPH, Associate DPH (health intelligence), Associate DPH (health outcomes), strategic lead for alcohol and 1 alcohol commissioner from Rosetown allowed the research team (PI and RAs) to explain the project and its approach to co-creation and answer any questions. A local joint interpretation group, which our research partners named the alcohol and pregnancy research group, held meetings in March and August 2012, and May 2013. At the first of these meetings, our research partners decided the alcohol topic they wanted to focus on was reducing maternal alcohol consumption before, during and after pregnancy. This included improving guidance and education, identification and screening for alcohol (mis)use during pregnancy and improving access to alcohol services. In discussions at this meeting, the under-reporting of foetal alcohol syndrome and the impact of alcohol on children and families were highlighted as important local issues. This fitted with the strategic priorities identified by the HWB, and an awareness of the need for targeted work with children, young people and families. Clearly this topic was wide ranging and our case participants asked that we focus on their commissioning of some local insight work (primary data collection following a market segmentation approach) to gauge the views of local women and midwives on the acceptability and feasibility of interventions to address maternal alcohol consumption during pregnancy. The decision to focus on this topic was ratified by the project advisory group.
3.5.2.2 Fieldwork.

14 scoping interviews were needed to map out the organisations and systems involved in the chosen commissioning process. These were undertaken between May – September 2012. It became clear that stakeholders were spread over several NHS and LA organisations, (commissioners and providers), and this was reflected in our need to gain R&D clearance from six NHS Trusts. Table 3 shows interviewees by role and Table 4 gives an overall view of the research activity in both sites.

<table>
<thead>
<tr>
<th>Number of interviewees</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Elected member</td>
</tr>
<tr>
<td>3</td>
<td>Commissioners</td>
</tr>
<tr>
<td>6</td>
<td>Clinicians / service providers in primary and secondary care</td>
</tr>
<tr>
<td>7</td>
<td>Public health</td>
</tr>
</tbody>
</table>

Table 3: Participants by role in the English case study interviews

3.5.2.3 Observations.

Two observations of the Alcohol Strategy Group (ASG) were undertaken in 2012 and 2013, one alcohol and pregnancy workshop in April 2012, one Health and Wellbeing Strategy workshop in May 2012, and one celebration event for alcohol advice and brief intervention work in early 2013. Observation of one ASG meeting was missed due to severe weather conditions in late 2012. In November 2013 a meeting between the Insight team, the commissioned market research organisation to report on findings from the commissioned process was also observed. Written, informed consent was obtained from all those attending each meeting we observed. Two of the planned meetings of the ASG and one of the alcohol and pregnancy research group meeting were cancelled as participants gave their apologies citing pressures created by the public sector reforms and new organisational arrangements making attendance impossible.
3.5.2.4 Documentary data.

In Rosetown the research team had access to the local Alcohol Strategy Group minutes 2011 - 2013, the HWS 2012 – 2015; the JSNA 2011, the LA and PCT Alcohol Strategy 2011 – 2014; the Insight Team Service Evaluation specification (2011); local health inequalities and local PHO data; a university partner’s research, and local professional newsletters (full details withheld).

3.5.3 Research managers

Research managers (i.e. those people whose role it is to gather, collate and supply evidence into the case study process, or perhaps to create that evidence) across the two sites worked in a range of job positions across sectors, including:

- Substance Misuse Specialists and Research Programme Managers based at local Universities;
- Heads of Library Services/Specialist Librarians & Public Health Consultants based in the NHS;
- Public Health Intelligence Managers, Strategic Policy Officers and Senior Marketing Executives within City Councils; and
- Operations or Information Managers within strategic partner organisations, such as Crime and Safety Partnerships.

<table>
<thead>
<tr>
<th>Research Process</th>
<th>Thistletown</th>
<th>Rosetown</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negotiated entry meetings</td>
<td>3</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Meetings with the joint interpretation group</td>
<td>4</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Scoping Interviews</td>
<td>4</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Interviews</td>
<td>15 plus 5 research managers</td>
<td>17 plus 6 research managers</td>
<td></td>
</tr>
<tr>
<td>Focus groups</td>
<td>2 (n=5 &amp; n=6)</td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>Follow-up interviews</td>
<td></td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Observations</td>
<td>6</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Table 4: Summary of the research activity in both sites

<table>
<thead>
<tr>
<th>Event/Round</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st round (Aug – Nov 5th 2013)</td>
<td>34</td>
</tr>
<tr>
<td>2nd round (November 2013) at workshop</td>
<td>(10)</td>
</tr>
<tr>
<td>Extra 1st round replies to end of Nov ‘13</td>
<td>39</td>
</tr>
</tbody>
</table>

3.6 Data analysis

3.6.1 Qualitative data

All qualitative data was entered into N-VIVO 10. Using a focused framework analysis approach (185) but also being open to emergent and unexpected themes and issues, the RAs met frequently to discuss the programme theories, emerging themes; categories and competing interpretations (as per Geertz’s thin and thick descriptions (186) and foster inter-rater reliability. Early analysis was further tested in fortnightly meetings with the PI and in other meetings with members of the research team and consensus was reached. Overall, this built-in multiple chances to identify known issues, explore newly emerging findings and look for generic and transferable messages. It also allowed the team to identify when data saturation had been reached.

3.6.2 Quantitative data

The quantitative data was managed within Excel and SPSS (as appropriate) after being cleaned.

3.6.3 Data and analytical synthesis

Each data stream: case studies (interviews, observations, documentary analysis, 2-stage modified Delphi survey, national interactive seminar) has been subject to its own analysis and this yielded varying (but partial) perspectives on research utilisation in the commissioning (or JP) process. To synthesise and combine data from these multiple sources we conducted a
thematic high-level ‘read across’ to identify recurrent themes and commonalties across the case studies (and other data sources) as well as to highlight places where managers’ use of research varied (within that context) and to explore why. An analysis of the programme theories permitted the testing of the assumptions behind how research utilisation ‘works’.
4 The Scottish case study – evidence use in the alcohol licensing process.

4.1 Background & context

Alcohol use is recognised as a key feature within Scottish culture (117), it is also a key problem (187). Evidence identifies that in recent years levels of alcohol use among the population and use at levels above recommended limits have increased as have levels of alcohol related harms (188, 189).

Alcohol is associated with health harms that can occur in the immediate short-term such as intoxication, accidents, poisoning and increased vulnerability. It is also associated with poor mental health and is a key risk factor for many chronic long-term conditions (189-190). Whilst many regular drinkers currently experience no noticeable problems, many alcohol related health conditions are complex and develop unnoticed, over time.

In Scotland, liver disease is growing at one of the fastest rates across the world, whilst alcohol related mortality has doubled within the last 15 years (117, 190) and one in twenty deaths result from alcohol related conditions (188). The personal, social and economic costs of alcohol to Scotland are estimated at over £7 billion (189).

Alcohol misuse does not only affect a minority of the population, it impacts across society (117), it is “no longer a marginal problem, with up to 50% of men and up to 30% of women across Scotland exceeding recommended weekly guidelines” (117:7). The scale of this issue could be higher as people underestimate their alcohol consumption and self-reported data is typically underreported (117, 187).

Increasing levels of population alcohol use, the associated health, social and economic harms coupled with continuing high levels of alcohol related hospital admissions and mortality rates present key public health challenges for Scotland (191). The increased availability and affordability of alcohol and the normalisation of regular drinking and home drinking are factors which have contributed to this increase in population consumption (119, 192-193). Alcohol was 66% more affordable in 2009 than in 1987 (190). In recent years alcohol purchases from off sales, often purchased from supermarkets at lower prices, and home
drinking have increased, and there has been an increasing concentration of drinking venues in city centres (194).

Some authors suggest that the harms caused by alcohol can only be curbed if population alcohol consumption is addressed, with measures introduced to address affordability and availability of alcohol (189). In an attempt to achieve lasting social and cultural change, the Scottish Government have consciously adopted a population level approach alongside targeted interventions for specific high risk and vulnerable groups (117, 119). At the time of writing Scotland’s decision to introduce a nationwide policy on minimum unit pricing of alcohol is being legally challenged by the Scottish Whisky Association.

Nationally, and internationally, the research evidence is extensive: the density of alcohol outlets; extension of hours of sale for both on and off trade; and changes in drinking patterns, combined with extensive advertising and promotion of alcohol have been linked with increased consumption and associated harms (193). Mobilising and using this evidence effectively to inform licensing decisions offers the opportunity to restrict alcohol availability and address public harm. For example: by controlling the overall numbers of premises, hours of opening and business operations, alcohol licensing is an example of a population level approach that addresses availability and affordability of alcohol (191). Yet, as we will illustrate, public health faces a key challenge in effectively applying what is largely population level evidence at the localised level needed for licensing decision making (191-192), amidst a backdrop of powerful vested interest, differing notions of ‘well-being’ and the constraints of legal process.

Public health involvement in alcohol licensing is supported by legislation in Scotland (195-197). The public health licensing objective was introduced in The Licensing (Scotland) Act (2005) (195). This objective was designed to enable, public health evidence to enter the consultation process and be considered in licensing decision-making alongside other evidence. This chapter presents findings on the use of public health evidence within the alcohol licensing decision making process in the Scottish case study site (Thistletown).
4.1.1 Policy context - the process of joint planning for alcohol services

In Scotland, responsibility for health and for NHS services is a devolved matter. The Scottish Government sets national objectives and priorities for the NHS in Scotland, signs delivery plans with each NHS Board, monitors performance, and supports Boards to ensure achievement of key objectives. NHS Boards work closely with their partners including patients, staff, local authorities and the voluntary sector to deliver services and to safeguard and improve the health of their residents. Since devolution there has been strategic development to support for the principle of the NHS and LAs working together in the design and delivery of services. This is embodied in the development of Community Health Partnerships (CHPs) in the early 2000s but the principle also extends to other complex and interconnected public health issues such as health inequalities and alcohol.

At local level, CHPs (or Community Health and Social Care Partnerships – CH(C)Ps) manage a range of local services delivered in health centres and clinics, the community and homes across Scotland. The inception was a response to the challenge of:

“…improving joint working to deliver modern and effective person-centred services, to identify options for charging for home-based care, and sharing good practice. The focus was initially to be on older people, but eventually to move on to other client groups, including children.” (198)

Currently, these are formal structures that ensure close involvement of LAs, patients and the public. These structures support the integration of health and social care planning and delivery. They also allow a coordinated focus of prevention at local area levels.

The principle of aligning planning and delivery between LAs, the NHS and other local partners is embodied in the establishment of Alcohol and Drug Partnerships (ADPs). The National Framework for Alcohol and Drug Partnerships (2009) set out the new arrangements for the strategic governance of alcohol and drugs services across Scotland. The framework provides an emphasis on joint working across a wide range of agencies involved in tackling alcohol and drugs issues at a LA level. In particular, there is a focus on ensuring participation from partner agencies to ensure there is commitment to taking forward the strategic direction of the development of alcohol and drug related services. The ADP is the structure that allows this, embedded within LA Community Planning arrangements; they involve not only the local CH(C)Ps but also community groups and organisations, Education, Licensing Boards,
ADPs develop local strategy to address policy outlined in Scottish Government documents (117, 199) and also Single Outcome Agreements (agreements between the Scottish Government and Community Planning Partnerships which set out how each will work towards improving outcomes in a way that reflects local circumstances and priorities). Within the Scottish Government’s alcohol strategy documents, the need for joint working between the NHS and LA partners is made explicit in the requirement to invest in prevention and treatment services alongside building an environment that supports cultural change.

4.2 The process of alcohol licensing in Scotland

Below we give a generic overview of the licensing process in Scotland, as identified in the data, before going on to present our findings. The alcohol licensing process is a complex, legally governed, decision-making process. Information and evidence from many diverse and sometimes competing sources enter and flow throughout the system ultimately leading to a decision made by the Licensing Board as to whether an application for a specific premise’s licence to sell alcohol, or change the terms of an existing licence, is successful.

4.2.1 The Legislative Framework

The alcohol licensing process is heavily regulated. The process that is mandated both creates prescriptive opportunities for evidence use but also constrains the freedom of those involved to request evidence outside this process. The current legal framework and policy guidance for alcohol licensing has been set out by the Scottish Government. This includes:

- The Licensing (Scotland) Act (2005) (195)
- Criminal Justice & Licensing Act (2010) (196)
- The Alcohol etc. Scotland Act (2010) (197)
4.2.1.1 Statutory Bodies - The Licensing Board.

The Licensing (Scotland) Act (2005) stipulates that every LA must have a Licensing Board (the Board) and a Local Licensing Forum (the Forum). The Board is made-up of between 5 – 10 elected members. Licensing Boards are a separate legal entity to councils and have their own constitution and statutory procedures which differ from those applicable to councils and council committees. The Board is required to be an independent and impartial tribunal. The role of the Board is to regulate premises that sell alcohol to the public. Legal advice is provided to the Board by the Clerk to the Board, a legally qualified member of staff within the council.

4.2.1.2 Statutory Bodies - The Local Licensing Forum.

The Forum is a multidisciplinary group comprising key stakeholders with an interest in the sale of alcohol and its consequences. Forum membership differs from locality to locality however typically includes representatives from the alcohol trade, adult social care, police, communities, environmental health, and the legal profession. Forums were introduced within the Licensing (Scotland) Act (2005) which stated that each LA should have a Forum and that membership must include a licensing standards officer. The Alcohol etc. Scotland Act (2010) first stipulated that a health representative (or someone nominated by health) should be included in the Forum membership. To ensure this was actioned, Forum membership could be increased by 1 or 2 places to accommodate health representation.

The Forum meets quarterly. The role of the Forum is to review the operation of the licensing system within their locality and to give advice, make representations and provide recommendations to the Board on general licensing issues but not in relation to specific cases. The Board is not required to act upon this advice or recommendations, however if they chose not to, the Board must provide the Forum with the reasons underpinning this choice. Legislation stipulates that the Board and the Forum must hold at least one joint meeting per calendar year.
4.2.2 The Licensing Board Policy Statement

The Licensing (Scotland) Act (2005) requires each Licensing Board to develop and review (every 3 years) a Statement of Licensing Policy that will guide the work of the Licensing Board. Policy statements can be reviewed and amended within this three year period.

Each licence application and variation is considered on its own merits, however, the Policy Statement sets out how the Board will meet the five licensing objectives in order to provide applicants, the public and responsible authorities, with information in advance, of the Boards general approach to licensing. The Licensing (Scotland) Act 2005 requires Boards to carry out an assessment of overprovision and include this within policy statements. In determining overprovision, Boards must consider the numbers and capacity of licensed premises within the area. This statement of overprovision further guides decision making.

In this way, typically, once every three years, current research evidence is gathered, and embodied in the policy statement. The evidence is applied to the local area to map out areas designated as overprovided. The Board must operate within the bounds of their Licensing Statement when considering licensing decisions; however Board hearings are civil not legal processes. This difference is significant and will be explored later.

Within legislation, there is a rebuttable presumption that a licence will be granted unless there is significant information to the contrary that is brought forward or unless it can conclusively be shown that to grant this license would contravene at least one of the 5 licensing objectives within the Alcohol etc Scotland Act (2010).

4.2.3 Making licensing decisions – the legal process

The Licensing (Scotland) Act (2005) identified five Licensing Objectives. These objectives form the foundation for Boards to develop policies that will promote safe, social drinking. The application of Licensing Objectives is key to the Board’s ability to carry out their functions within legislation. Whilst the policy statement sets out the Board’s general approach to decision making it does not counter an individual’s right to make a licence application.
Information and research evidence that is brought forward to challenge a licence application can only be done so under the five Licensing Objectives. These five objections are as follows:

- Preventing crime and disorder;
- Securing public safety;
- Preventing public nuisance;
- Protecting children from harm;
- Protecting and improving public health (Note: in England within the Licensing Act (2003) there are 4 licensing objectives. There is no public health licensing objective in England.)

For each licensing application or variation received, the Board must seek information and evidence in writing prior to the licence hearing from a number of statutory consultees. Details regarding each individual licence application are also posted in local communities and any person or organisation may lodge an objection, to a licence being granted, under one or more licensing objectives. Statutory consultees include:

- Police Scotland
- Licensing Standards Officer
- Environmental Health
- Health

Health were appointed as a statutory consultee within The Alcohol etc Scotland Act (2010). As such, a locally designated department within the Health Board receives a written request to respond to all new and major variations to premises licences. For a response to be considered by the Board, the response (research evidence, data and information) must be formally presented in writing, and in person if desired, within the public domain of a Board hearing. Case law, prior legal precedent, current legislation and local knowledge are also factors that influence alcohol licensing decision-making. Research evidence, data and information presented in person is open to questions from members of the Board and from those present at the hearing. If a statutory consultee does not make a response then the Board
in unable to request this information as, under the legal process, this could be considered prejudicial to the applicant.

Once furnished with all the information the Board retreats from the public meeting and convenes (in private), with the Clerk to the Licensing Board (who is legally trained), to consider the material presented and come to a decision regarding each license application. If a license is refused, or conditions are applied to a licence, the applicant may challenge the decision by lodging an appeal in the Sherriff Court. This is a legal process and can be costly if the Board’s decision is overruled with the council bearing the costs from the public purse. (N.B. to preserve confidentiality we refer to the Scottish site as Thistletown).

Figure 1: Summary of the core process for alcohol licensing in Thistletown

4.3 The alcohol licensing process in our Scottish case study site

Below we systematically go through the process of granting licenses in our case study site, to explore where and how research evidence and other types of evidence enter the process. To do this, we overlay the simple diagram above (Figure 1) with a series of sub-process represented diagrammatically. These diagrams are heuristic to illustrate the process, the groups and statutory bodies involved, and the way evidence enters and passes between them.
The licensing process is, of course, embedded in wider socio-politico-cultural, economic and legal processes both within and across local government, health, and other statutory bodies. The context creates both structural and person-dependent opportunities for, and constraints on, what can be achieved (structure and agency). As well as the formal statutory bodies and the legislated ways in which they can and should operate, information and knowledge passes through the process, informally. The prevailing beliefs, customs, and ideas of what is valuable and constitutes a ‘good outcome for those involved’ enter the process of decision-making in the expectations, relationships and actions of those involved. With members drawn from multiple interest groups, it is not unreasonable to expect that these interest groups have their varying ways of seeing the world and hold differing values and views. Below we illustrate how this wider canvas of knowledge and beliefs enter the system both as a backdrop (context) to the system (structure) and via the people involved (agency).

In Figure 3 we illustrate where information flows around the licensing process, how it is pulled between the different bodies and pushed into them via the communication mechanisms they have. Outputs from the Board flow to the Scottish Government (issues they were unable to address locally), the Board pulls information in from consultees, they have information pushed to then from trade bodies and they both push and pull information to and from the
Forum. The Forum also directly pushes information into the formation of the policy. Below we expand upon these processes and try to tease out to what extent research evidence is included in this flow of information.

4.4 Findings - what evidence is used by whom and for what purpose?

Research evidence formally enters the licensing process in three main ways: via the Board policy statement, via Board hearings and via the Forum. Each of these represents formal evidence entry points – specific places in the process where evidence can be formally introduced and potentially mobilised in the decision-making process. Each of these three points are described below to illustrate how the formal EEPs are actually used in Thistletown and how the action is shaped and modified at every stage by informal processes and other types of knowledge and information.

4.4.1 The Licensing Board Policy Statement

Licensing Board’s Policy statements must include evidence on the density of provision in the geographical areas under the Board’s remit and identify areas of overprovision. In this sense the evidence base on reducing the harms created by the wide availability of alcohol is embedded in Board policy and has the capacity to inform all decisions taken during the life of that policy. However, participants acknowledged that whilst Licensing Board Policy statements may be evidence based, they merely guide Board decisions and allow flexibility in decision making:

“I mean the Board have a policy, which they don’t have to follow, they can make exceptions from it, when they are looking at a particular application.” (participant 14 emphasis added)

It was acknowledged that many and varied reasons underpin decisions and that decisions are dependent upon the specific circumstances and evidence presented to support or counter individual applications. The formal process of a Board hearing was considered useful in providing an arena for evidence from all interested parties to be presented thus enabling the Board to make an informed decision. However, who presents information and the amount
that each party presents varies suggesting that input may not be balanced. Whilst this process was recognised as highly formalised it was acknowledged that Board hearings are not legal courts and it was highlighted that evidence and information presented to the Board to aid their decision making was not stringently tested.

“People will provide you with what they believe is either appropriate or they'll provide you with what’s mostly convenient. Now, you also don’t know whether they’re providing you because it’s convenient or whether they feel its most representative, or whether they feel it’s showing a spike and that’s what they are looking to show, you don’t know if there’s an agenda to the provisional data” (participant 17)

Flexibility was valued as it allowed Board members to take local knowledge into account and use their discretion to temper this against the evidence-base (as embodied in their policy statement). Where the policy statement was over-ruled (e.g. license granted in an ‘over-provided’ area), some participants felt that economic vibrancy and politics were key elements underpinning such decisions. Participants felt that there was an opportunity for the Board’s overprovision statement, if used in conjunction with the Public Health Objective, to be better applied to refuse or restrict such applications.

Boards are made up of elected members. Some participants felt this was important as it ensured a good understanding of local knowledge. In Thistletown Board members are proactive in trying to understand the context of specific premises and the communities within which they will operate and regularly make site visits to inform the decision-making process. This local knowledge and ‘feel’ for the setting was highly valued by Board members. Conversely, participants highlighted that Board members were not likely to be expert in all the issues that would need to be considered in the decision making process:

“I’m not sure any of the elected members that sit on the Board have spent any time with their [specific piece of local research] people or any of the local Alcohol and Drug Partnership (ADP) structures or anything that would give them a particular insight into the alcohol issues in their community […] So there’s quite a lot of local knowledge they will not have” (participant 16)

So whilst local knowledge was thought to be important in decision making, participants felt Boards could, and should, rely more upon input from statutory consultees as topic specific
experts. This represents a second evidence entry point where statutory consultees along with licensees and any individual or organisation could present evidence in order to shape decision-making. We start to see the emergence of different knowledge types: situated embedded local knowledge and ‘context-free’ research evidence being brought into play by different groups.

4.4.2 License Board Hearings - health as a statutory consultee

Within Thistletown, at the time of this research, all participants identified that the statutory consultee role was not a role that health had embraced or actively taken forward, indeed, health were considered to be unfortunately missing.

“They’re statutory consultees; they get the information sent to them in an envelope marked ‘for your attention’” (participant 1)

“It’s difficult for me to assess, I can’t tell you anything about the evidence they might provide because there hasn’t been any” (participant 4)

“I’m not trying to be critical, but it’s just there’s a noticeable absence, if you like, of comment in a very relevant area [health]” (participant 5, legal)

However, it is acknowledged that this research took place at a specific time and findings may have been different had the timing of data collection been different, given the history of the Board. This appears to be a conundrum if Health are deliberately missing one of the statutory chances they have to enter public health research evidence, data and information into the decision-making process. In Thistletown, failure to engage within the role of statutory consultee was considered by non-health participants to be a stance actively chosen by health, an issue not entirely disputed by health participants. Participants with an active role in licensing beyond Thistletown stated that disengagement of health within the statutory consultee role was not unique to Thistletown. These participants felt that the introduction of the statutory consultee role for health had not improved the provision (quality or quantity) of health evidence, data and information to Boards across Scotland. One interpretation offered (identified as occurring throughout Scotland), is that legislation introduced statutory duties in advance of the readiness of Health’s capacity to respond.

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Some of the reasons participants felt Health did not engage (across Scotland) were identified within interviews as:

- There is little or no capacity to respond (writing a written response to each application);
- inappropriateness of public health data to comment at the individual level needed by each license and a recognition of the difficulties encountered;
- therefore, a deliberate decision to concentrate resources elsewhere based upon previous unsuccessful experiences at influencing licensing decisions.

We expand upon each of these below.

4.4.2.1 Capacity to respond

Within Thistletown there is a high volume (“there are 30 plus a month” participant 16) of license applications to respond to. With a rebuttable presumption in favour of granting each license the Board requires public health to consider each application or major variation to an existing licence and decide if they wish to raise an objection. A ‘blanket’ overprovision statement does not refute the rebuttable presumption. Participants identified that for some time they felt that there had been a lack of clarity within ‘Health’ as to which department should be responsible for responding as the statutory consultee. Some non-health participants felt there was a disconnect between the strategic sign-up of the Health Board and the Health Board’s capacity to fulfil the statutory consultee role.

The Health Improvement Directorate have now taken on the role to respond, but have little capacity within existing staff workloads to be able to meet this obligation. In addition, staff tasked with responding within this role have limited knowledge about alcohol licensing and how public health data can best be used to influence individual licensing decisions.

“discreet licenses that [health] staff didn’t even know existed, never mind give a view on how relevant or appropriate that might be to give that licence or change that licence… staff are not research based staff. They are not staff that actually spend their days going and finding out what is the academic evidence base for this, that and the other. They are more staff that are around implementing what comes from some of this” (participant 16)
4.4.2.2 Inappropriateness of public health data to be utilised at the individual level needed

Regardless of health’s capacity or readiness to respond, questions were raised about whether the evidence-base around alcohol and health was able to answer the questions posed by individual license applications. Whilst health have an obligation to respond within their role as a statutory consultee, all participants stated that existing health and Public Health data (typically population level data and often historic), is difficult to apply at the individualised level needed for specific licensing decisions. In many instances, for example specific licensed premises or variation applied for is not yet operational, and legal challenges can therefore question the contribution to harm by this license which is not in place yet. Participants recognized that any weaknesses or anomalies in data presented as an objection to a license could be exploited by licensing lawyers acting for applicants in any appeal situation. It was felt that to be more effective, health data needed to be more specific and localised than that currently used.

“to get the data of how many people go into A & E at 3 o’clock in the afternoon drunk, you know that’s the type of thing” (participant 3)

However, those participants who know the data well expressed concern that this level of precision is never likely to be possible.

“I don’t think we will ever be able to link health data and alcohol related harm to individual premises, I just think that’s impossible” (participant 9)

Whilst it was acknowledged that existing health data itself was difficult to apply at such a localised level, participants felt that it had the potential to have more value in adding strength to an objection when used alongside other data such as crime and disorder data. Participants identified the need for increased partnership working between statutory consultees (which is one of the recommended high impact changes (HICs)).

“…there’s real value to what they [Health] can bring to the table, but it must be mapped against what everybody else brings, because we don’t work in, we shouldn’t work in isolation.” (participant 12)

The role of ADPs was also raised as relevant in relation to the mobilisation of locally relevant health data. Whilst it was acknowledged that ADPs do not have a direct role as a statutory
consultee it was felt that they could be consulted by Health to provide data and input into any health response.

4.4.2.3 Concentration of resources elsewhere based upon previous unsuccessful experiences.

Participants with an active role in licensing beyond Thistletown stated that their experiences, elsewhere in Scotland, of health evidence being presented through the statutory consultee role (and related to the public health objective) often led to unsuccessful outcomes (i.e. license granted despite Health objections). This seems to suggest that the specific findings from Thistletown were neither atypical nor unusual in this respect.

Participants strongly felt that health should engage more with the statutory consultee role however the difficulties that this raised were recognised. The process is such that Health would be presenting evidence that is difficult to apply at an individual level, within the formal arena of a Board hearing, where it is open to examination, scrutiny and challenge from legal agents. Faced with these multiple difficulties of presenting and getting research evidence to make a difference to licensing decisions, it was acknowledged among health participants that, more recently health resources had been directed upstream into trying to inform local and national policies.

“…so if they [Health] are going along and it’s not making any difference to the application, then it’s possibly a situation they’d rather not become involved in.” (participant 14)

“…they [Board] are looking at individual premises, [Health] are looking at a population basis so [Health] have tried to have more influence at a national level, rather than at a local level.” (participant 9)

Turning one’s attention (and resources) to policy level, where population data may be better suited to provide answers is arguably a rational response by health professionals. However, non-engagement by Health with the statutory consultee role still has impact and is not a neutral outcome. Case study site observations by the research team and interview responses identify that where Health do not respond to an application, others, particularly the alcohol industry and their legal agents, infer that as Health have not responded there must therefore be no negative health issues related to that application. A public health objection does not
necessarily signal a ‘red light’ to applications, but a non-response is taken as a ‘green-light’. Whilst others are able to raise a health objection when Health do not, this lacks credibility because it is Health, as the statutory consultee, that are considered to be topic specific experts, not the person raising the issue in their absence. Health’s non response is often highlighted by Licensing Lawyers to signal that there are no health issues to raise. When Health do respond as a statutory consultee, participants recognised that it can be a difficult objection to refute. Some participants stated that elsewhere in Scotland when evidence was presented around the public health objective, licensees and their legal agents were being asked to return to later hearings and describe how granting a specific licence would improve public health, rather than Health being asked to state that it could be detrimental.

“What they wanted [lawyer] to show was that, to counteract the policy, was that by granting the application, there would be a benefit to public health. Which is impossible. I mean they were wanting to sell more alcohol.” (participant 14)

It was acknowledged that within the recent pre-consultation exercises for the current Board Policy statement review (2013; full reference withheld), Health had been involved. Engagement, specifically within the verbal evidence sessions, where Health presented data and supported community members to attend and present evidence about the community impact of alcohol use was highlighted as positive by both Health and non-Health participants.

“The presentation to the Licensing Board, and some community reps went along and provided a picture from a very much lived experience of alcohol, […] so in that sense there was capacity build up, where people actually go and tell their stories, and I don’t know what’s, what the Licensing Board have done with all of that, but I certainly understand they found it incredibly powerful. So those telling of stories probably has had a bigger impact than the evidence that we presented. But that’s good, because then you’re getting a holistic picture, not just one set of information to be able to tell a story” (participant 16)

“The drug and alcohol forum [ADP] were ones that came in, I think where the most balance between evidence and passion about the harm that drugs and alcohol do in the community because they’re not a dry, the health professionals, they’re people who are
actually working with communities and individuals severely affected by it […] and it almost worked better than dry academic health statistics, this was community based experience of the harm that alcohol can do to individuals and to families” (participant 7)

4.4.3 The Local Licensing Forum

As mentioned previously, the role of the Forum is to gather information for the Board, to give advice, make representations, provide recommendations and ask crucial questions to challenge the Board’s general licensing activity. The Forum is a well-attended meeting that participants consider provides an excellent opportunity to bring together a diverse range of stakeholders involved in alcohol issues; a good place to network. However, there is much uncertainty among participants around the actual role and function of the Forum and any actions arising from it. Many participants questioned the usefulness of the Forum:

“…do we actually understand what the Forum’s supposed to deliver, or does it leave you feeling slightly, erm, slightly disappointed at the end that we hadn’t gone with what we thought it would do.” (participant 12)

In relation to the Forum’s role in facilitating the entry and flow of evidence and information within the alcohol licensing process, participants raised a number of issues. Concerns were raised regarding membership of the Forum which it was felt could be more balanced than it is. Current membership was considered to stifle debate and decision making. Prior to the legislative requirement to have a Forum [198], an alcohol trade forum had been operational within Thistletown, the current Forum had developed from this. Several participants considered that the current Forum’s high trade and council representation and the (perceived) tendency for Forum business to focus largely upon non-contentious, practical day-to-day operational issues rather than more complex or strategic issues resulted from this.

“There’s an element where the Forum is almost a grandstand for self-interest.”
(participant 7)

Participants felt that the number of trade members on the Forum influenced discussion and proved a daunting opposition for less well represented organisations or individuals to challenge. The Convenor and Clerk of the Board also attend Forum meetings. In many ways this was seen as helpful as they could provide instant answers and feedback from the Board’s
perspective. However, it was also considered to stifle discussion, debate and any challenging of the Board by the Forum:

“The Convenor of the Board attends the General Forum [...] and whether that perhaps creates a reluctance, because people are conscious, if they came somewhere and they were critical to someone, two weeks later they could be in front of that person, [in] a hearing.” (participant 5)

Concerns were raised regarding how representative of Thistletown or focussed upon local issues the Forum is, as in some roles the member attending represents a national organisation, and is not a trader or practitioner in the case study site.

“…the level of membership you have got is not particularly local, it’s quite high level [...] rather than someone who runs a [premises] in the city centre who deals with customers. (participant 8 health)

Participants stated that communication between the Forum and the Board could be improved and that the Forum were not active enough in questioning the Board or formally asking for clarification of issues. Participants pointed out that the ADP was missing from the Forum membership but suggested that if they were present they could provide useful input and this could give the Forum a more strategic role. Involvement would also enable the ADP to raise issues within the Forum that when taken to the Board via the Forum would, within legislation, require acknowledgement, and a written, documented response (although not necessarily action).

“There’s not a huge amount of [pause] questioning of the Board’s policy or what they do comes through the Forum, erm, less than I anticipated.” (participant 5)

“There’s been little visibility of that ADP strategy at the Licensing Forum. So they have not got a common, if you like, strategic vision or direction. I think that they would share. Therefore there’s nothing in the commissioning programme that’s been informed by licensing.” (participant 11)

Some members of the Forum however, were also members of the Alcohol and Drug Partnership. Information sharing between groups was thought by participants to be lacking with some participants realising that perhaps they could do more by acting across their
varying professional roles. Inputs of evidence into the process that are person dependent literally depend upon that person(s) to activate them and to share information, intelligence and research evidence across their multiple professional roles:

“Part of the conversation today is about what my role is and I’ve always to date I have gone to react or respond to something, rather than proactively bring something along to the agenda.” (participant 11)

Participants felt that the Forum produced, at best discussion, but no action. Any evidence or information presented consisted of regular long reports or updates and ‘stories’ but little that stimulated debate.

“A lot of things get read out that have been circulated prior to the meeting anyway, and then there’s a limited amount of discussion, but it doesn’t seem to go anywhere.” (participant 9, emphasis added)

The diversity of Forum membership was highlighted by participants as a factor underpinning the lack of debate and actions coming from Forum meetings. Participants felt that there were many differing and competing interests among members making agreement and action difficult to achieve. The lack of action from the Forum frustrated participants and most struggled to see the benefit of the Forum in its current format. Many had become disengaged and frustrated. Disengagement often led to non-attendance or deputising attendance which could further stall issues.

“If there was a clash in my diary, it wasn’t a thing that I prioritised for a time” (participant 9)

“It has to be the right person at the right meeting to be able to do all of that, but also then make decisions that the Forum can be trusted that are going to be taken back by your industry and move forward. That there’s a level of responsibility on the participants and delegates that they are not just there to keep a seat warm” (participant 12)

What we can see is that whilst the forum provides a structural place for entering evidence it is the action of its members that turn it into an evidence entry point (201). Some participants felt that a lack of clarity around the role of the Forum and a lack of leadership and direction
also impacted upon the ability of the Forum to move issues forward. Others went further and suggested:

“I would say that the matters discussed, erm, the challenges are about the agendas of the table in the room, in terms of the participants in the room” (participant 12)

Evidence or information for discussion within Forum meetings must be requested or put forward by a member. All issues to be tabled, must be submitted in advance and are discussed at a pre-meeting by the convener of the Board, chair of the Forum, and clerk of the Forum. At this meetingForum agendas are agreed. Most participants could not remember any research evidence or information being presented at Forum meetings aside from reports from the Licensing Standards Officers and updates from the Local Community Safety Services Initiative. In this way, being included on meeting agendas is another possible evidence entry point.

In addition, among participants, no one was really sure how well information from the Forum was cascaded among individual members’ own organisations, the Forum appeared to neither pass on information (to the Board) nor pass it back (to the members they represented). Minutes and meeting documents are public documents and are available on the council website, however participants did not think awareness of this was high among the public and considered that access was sought by only a limited number of people.

Participants involved in alcohol licensing outwith Thistletown site reported that the issues identified within this research around the Forum were not uncommon across Scotland.

4.5 What evidence enters and flows - using the evidence entry points

4.5.1 Health research evidence and health–related data

Health participants confirmed that health research evidence and health-related statistics (prevalence, trends and projections in alcohol-related harms) had been presented at Forum meetings. This was not a common event, but some participants recalled the presentation of this evidence to the Board and Forum and provided for inclusion in previous Licensing Board Policy (2010; full reference withheld). The presentation and written evidence had largely not been well received for various reasons. It was considered to be:
• too complicated to understand; (i.e. statistical terminology, key messages not pulled out), as one participant said: “it was presented for an expert audience and even then I’m not sure an expert audience would have taken it on.” (participant 17)

• overly generic; (originating in different places and not focusing on how those issues were manifesting locally, in order to suggest honed responses);

• contradictory of itself;

• out of date;

• lacking actionable messages (i.e. stated the size of the problem, but lacked practical solutions);

• data not evidence (i.e. not defining if an issue recorded was one person 100 times or 100 people once – each requiring a different response, a focused service or policy response). Data was also not mapped against local areas in a way that identified options for targeted action.

“They did provide health statistics, but the Board considered that it wasn’t erm relevant enough, it was too generalised for them to form any conclusions from that information. And therefore it didn’t really assist in the development of policy, other than to raise general concerns about,  erm, alcohol consumption levels throughout the city.” (participant 4)

Participants stated that evidence did not ‘speak for itself’, nor were its messages clear or obvious. There was always more than one interpretation of any data presented. Some participants felt that during Board hearings, licensing lawyers (acting on behalf of their client who was seeking a license or variation to a license) actively sought to unpick data presented by Health as the weaker data, undermining its significance.

“It wasn’t well received because sometimes it wouldn’t be what people wanted to hear, there was also a comment that because it was quite a complicated formula, that that detracted from the message… How much of that was; “we actually don’t want to grasp” it I don’t know.” (participant 15)
Overall, participants thought that Health considered their key role in relation to alcohol licensing to be one of strategic involvement and raising public and media awareness rather than engagement with day-to-day operational licensing issues. Where health information does flow participants highlighted the gathering and presenting of the information in a straightforward way as key to its success. Participants involved within alcohol licensing decision making within Thistletown felt that across Scotland, health information worked better when it is presented in a more localised way. It was acknowledged however that even when health information does become part of debate and policy it is not necessarily followed through into decision making.

Health input into the evidence sessions recently conducted as part of the pre-consultation exercise for the SCSS’s Board policy statement review were however highlighted by participants as positive as this input combined statistics and data with real community stories and impact was easier to understand.

4.5.2 Local data and statistics and community stories

Within Forum meetings the only information regularly presented (aside from the Licensing Standards Officers report) was an update report from the Local Community Safety Service initiative. This information was presented at every Forum meeting observed (September 2012 – September 2013). Information was well presented in an easy to understand language and graphic format. It included information about the night-time economy, footfall and operation of different elements of the initiative within different localities and was case study site wide. No participant was able to remember when or why this presentation became a regular agenda item but there was widespread consensus that the information was of interest (in many different ways) for all parties within the Forum:

“…that’s very valuable information, from my point of view having seen that, that information that will be relevant to the trade members, there because it’s about footfall and it’s about [Thistletown], it will be relevant to the police and to Health as well.” (participant 6)
Some participants however felt the information promoted no debate or controversy (strategic issues) and was very much just an information update (operational) and therefore questioned its added value:

“…it’s not problematic to anybody… it doesn’t create any, it doesn’t create any err, real debate or arguments as a consequence, because it does tick all the boxes”
(participant 11, emphasis added)

When evidence ‘ticks all the boxes’, is an interesting concept. It seems to encapsulate ideas about data from here, now, related to daily pressing issues, that something can be done about, and we return to this notion in the discussion chapter (chapter 8).

4.5.3 Competing information and contextual pressures

Participants acknowledged that in relation to alcohol licensing, health was only one of a number of issues that would inform decision making (and often, for some, not the most important) (37). Below we explore some of these other contextual factors and how they played out in Thistletown to inform alcohol licensing decision-making.

4.5.3.1 Economic wellbeing.

Economic wellbeing and regeneration opportunities often offer alternative perspectives on ‘what is the best decision’ and pose important (sometimes competing) considerations. Participants felt that one of the key factors was the economic wellbeing of Thistletown. Economic wellbeing was related to both on and off trade license applications and participants considered that the Board would be under pressure from the electorate, businesses and others within the council to ensure that in considering applications they took into account all perspectives.

“The economic effects as well as jobs [retailer] come into an area and as a result the actual health if you like, thing, is always competing with you know business, and business demands, […] any arguments that health have got seem to be put on the back
burner, ahead of err, votes at elections and ultimately erm, business finance and you know the economy of the local authority area” (participant 3)

Economic well-being (taken together with the rebuttable presumption in favour of granting a license) was highlighted by some participants as potentially having greater influence than the overprovision policy and statement. Some participants considered the influence of economic wellbeing to be so great that there could almost be an additional unwritten licensing objective around promoting economic wellbeing.

“…there isn’t an economic objective but you would think there was, the way people kind-of carry on talking about it” (participant 8)

“I can guarantee you now the Licensing Board will never say the entirety of [Thistletown] has overprovision. Sorry, there are all sorts of economic reasons and developmental reasons, why doing that would be suicidal and the rest of the Council would be on the Licensing Board like a ton of bricks. Because you would stop any hotel, you would stop every major, err, economic development and shopping centres, etc, etc. It isn’t going to happen.” (participant 13)

Whilst all participants recognised and supported the need for Thistletown to be a vibrant, thriving and desirable night time destination and a good place for businesses to invest in and bring jobs to, there was acknowledgement that it was necessary to find a balance between economic wellbeing, health and harm.

4.5.4 A backdrop of political influences

Participants felt that power and politics were factors that influenced the flow and use of information and evidence within the alcohol licensing process within Thistletown. This was noted in both observations of the Board and Forum meetings and within interviews.

4.5.4.1 Local Licensing Forum.

As previously highlighted within this Chapter, getting information and evidence onto a Forum agenda for discussion is subject to that document being accepted at a pre-agenda meeting. As well as being able to refuse documents the pre-agenda meeting is also able to
defer documents for inclusion at future quarterly meetings which could impact on the relevance of the issue at a given time.

Participants expressed concerns that although all Forum members had the same opportunities to contribute within Forum meetings, there was a feeling that not all voices were expressed or listened to. The power and political (small p) dynamics of Forum membership was identified by participants as an issue underpinning this. As previously mentioned, the Forum has a high membership from the alcohol industry and participants were concerned that this provided a dominant professional contingent around the table which could be daunting to challenge.

“You need to be sure that you could have an impact that was worth fighting that”
(participant 9 – emphasis added in italics)

Some participants were overt about the influence of politics and power within Forum meetings and the potential to use this to their advantage.

“…sometimes I have to play a political game and I don’t necessarily want to oppose everything that [others] suggest. So there’ll be occasions when I’ll need their support on issues so I gave that support” (participant 2)

4.5.4.2 The Licensing Board.

There was concern among some participants that the power they perceived to be held by larger corporations within both on and off sale applications was a factor that influenced the decision making process. Such organisations were thought by participants to be likely to have excellent legal teams working for them and in cases where licensing decisions were not favourable, sufficient funds to risk an appeal against the decision.

“Like everything in life and everything where there is regulation, people who are part of a big organisation, who have better resources, have the ability to employ lawyers and accountants, and folk that can turn round and put forward the eloquent cases”
(participant 5)

“They’ll give [supermarkets] a hard time, don’t get me wrong, they’ll give them a, they’ll go through the motions and give them a right hard time about why the area needs another, but [supermarket’s] and stuff they just produce all these documents
about how, how much they’re investing and, you know, making things better, and reducing their alcohol range and all these investments, we’ve engaged in this and that, erm, to and then they’ll get, they’ll get a hard time. Oh well, we’re not, right OK, granted and they get that.” (participant 3)

4.5.4.3 Negative Stereotypes.

Difficulties in communications and perceived lack of responsiveness on both sides (Health’s perceived failure to submit public health objections or engage in the process and the Board and Forums’ perceived unwillingness to make licensing decisions in line with the prevailing public health evidence-base) led to negative stereotypes on both sides.

The perception of ‘health’ and ‘the health lobby’ was of a discipline that is lofty and elitist. Health participants spoke of their own belief that ‘Health’ as a discipline is perceived as lecturing people about what should be done. They believe that others perceive health messages and health thinking around alcohol as having a single negative and gloomy focus - no alcohol is good for you - which ignored alternative recreational and social interpretations of alcohol use. Health participants believed that because people felt that they had heard the negative message so often they now disengaged from it.

“…as having a single agenda, maybe [Health] do in that respect, but as a consequence of that, err, it is seen as a single err, and being single and repetitive and I think it loses its effect over time because it’s the same message they see.” (participant 11)

“…the community don’t want to hear the health message either, do you know… they don’t want to hear it, the Board don’t want to hear it, the Forum don’t particularly want to hear it, erm, no one particularly wants to hear it.” (participant 8)

Conversely, there was a tendency to attach negative stereotypes to the Board and Forum decisions with concern that they were influenced by the pressures of the night-time economy. Some participants questioned the appropriateness of the high percentage of membership from the alcohol industry, specifically the alcohol retail trade within the Forum membership, given
the role of the Forum in relation to the Board. There was concern raised that this influence could have an impact upon granting of future licenses.

“I don’t know whether the right people are influencing the decisions because its people that are already in the market, not people that, you know, want to bring something new to [Thistletown] or that’” (participant 14)

4.5.4.4 A balanced view?

Each party was aware of the negative stereotype the other sometimes held of their activity. Board and Forum members felt that the good work they had done was largely overlooked. They highlighted that whilst the statistics for alcohol related health and social harms in Scotland remain extremely high, they stated that locally there had been a downward trend in recent years (which is supported by the quantitative data see appendix 9). There was frustration among participants regarding this and the lack of recognition or praise afforded by the health sector generally to other organisations working to address alcohol issues, and the general population for, to some degree, taking on board more responsible drinking messages.

“…even in circumstances when they [Health] ought to pat [businesses and communities] on the back, for want of a better phrase. I’m thinking of some statistics that have come out where the admissions, hospital admissions on alcohol related issues, illnesses where they have actually gone down and other statistics that show that alcohol consumption has gone down […] and its galling at times when you feel there’s some improvement is being made and you don’t even get the credit for it.” (participant 2)

Often Board members expressed the opinion that they would like to be able to do more, but find themselves restricted by both the legal process and other competing demands. In Thistletown, with particular relation to alcohol licensing it was felt that health needed to engage more to understand the processes – especially the constraints placed upon the licensing process by the legal framework, i.e. in not being able to request evidence to overrule the rebuttable presumption in favour of granting a license. It was felt that this would improve any subsequent input or interaction as on occasions requests were made that were inappropriate and not within the power of the Board to enact.
5 The English case study - evidence use in commissioning to reduce maternal alcohol consumption

5.1 Background and context

In the English case study site (Rosetown) excessive alcohol consumption is identified as a growing problem, with mortality from chronic liver disease on an upward trend and currently is almost double the national average for England. The rate of hospital admissions for alcohol related conditions in Rosetown is one of the highest in England. (Latest figures available for Q2, 2012/13 show Rosetown was ranked amongst the top 10 out of 326 LAs in England (Q2 2012/13).) While alcohol related hospital admissions in Rosetown remain high, figures indicate levels have plateaued in recent years, mirroring the pattern seen regionally and nationally. Rosetown has significantly higher death rates than nationally and regionally similar areas, and is currently ranked in the top 10 LAs nationally for its male and female chronic liver disease mortality (2006-08). In addition, although alcohol related crime rates have fallen by approximately a third between 2007/08 and 2011/12 but remain significantly higher in Rosetown than the regional and national average for England.
Figure 4: Comparative trends in admission episodes for alcohol-related conditions (Rosetown, regional and national figures): Rosetwon

Source: (202) Note: Alcohol-related Definition: Alcohol-specific conditions (e.g. alcoholic liver disease or alcohol overdose) plus conditions that are caused by alcohol in some, but not all, cases (e.g. stomach cancer and unintentional injury). For these latter conditions, different attributable fractions are used to determine the proportion related to alcohol for males and females. Figures for 2011/12 were revised using mid-2011 population estimates, which in turn are based on the 2011 census, changes in the rate of admissions between 2011/12 and 2010/11 should therefore be treated with caution, particularly for smaller areas (LAPE Publication date 20/1/2013).

5.1.1 Policy context - the process of commissioning

5.1.1.1 Legislative changes and new structures.

The structures for commissioning healthcare, including maternity services in England and Wales, changed from April 1st 2013 as part of the reforms introduced under the Health and
Social Care Act (2012) (203) passed in March 2012. Until then, 151 primary care trusts were responsible for commissioning health services, overseen by ten strategic health authorities.

Responsibility for commissioning maternity services in England now rests with 211 Clinical Commissioning Groups (CCGs), overseen and held to account by NHS England, which is an arms-length body of the Department of Health but is operationally independent. CCGs commission maternity services from local providers, NHS Trusts and NHS Foundation Trusts, who are regulated by the Care Quality Commission. Individual health care professionals are regulated by the Nursing and Midwifery Council and the General Medical Council. Public Health England (PHE) is a new national body whose role is to strengthen and support the public health system by providing stakeholders with evidence-based professional, scientific expertise, evidence and intelligence.

NHS Commissioning Support Units (CSU) have been established to support CCGs in carrying out their commissioning functions, including transactional functions, such as healthcare procurement, contract negotiation and monitoring, and information analysis. CCGs retain legal accountability and responsibility for meeting their statutory functions and their commissioning decisions cannot be delegated to other organisations. (204)

The Health and Social Care Act (2012) required the establishment of a statutory Health and Wellbeing Board (HWB) in every LA in England from April 2013. Since then, responsibility for public health improvement has been largely transferred from PCTs to LAs in England. LAs have responsibility for ring-fenced public health funding from the DoH until 2015, which includes money to commission alcohol prevention and treatment services. LAs are expected to take the lead in coordinating local efforts to improve population health and reduce health inequalities, and provide public health expertise to NHS commissioners (205)

The role of commissioners is complex and involves assessing the needs of the population, planning and buying services, prioritising outcomes, overseeing and managing service providers, monitoring and measuring impact and planning next steps (206). An essential part of this process involves putting together a Joint Strategic Needs Assessment (full reference withheld), which describes current and future health and social care needs and inequalities impacting on the health and wellbeing of the population in the case study area. This strategic overview is designed to inform and influence the commissioning process and provide
evidence about what works to improve health and wellbeing outcomes for people across all stages of their lives.

Under a new duty, HWBs are obliged to prepare a Health and Well Being Strategy (HWS), for endorsement by their CCGs in line with their own strategy (or, if refused by the CCG, then sent for appeal) to respond to needs identified in the Joint Strategic Needs Assessment.

### 5.1.2 Commissioning for services in pregnancy

Pregnancy is the largest single reason for admission to hospital and for the average CCG of 250,000 people, around 3,000 women a year will use maternity services, costing around £8.6 million (160). Whilst responsibility for commissioning maternity and newborn services sits with local Clinical Commissioning Groups (CCGs), NHS England sets a national framework for quality and choice, including for antenatal and newborn screening services, and requires clinical services to be developed in accordance with the best available evidence. Commissioning responsibility for all public health services for children, including health visiting and family nursing are due to transfer from NHS England to LAs in 2015 (206) overseen by PHE.

### 5.1.3 Key to the classification of the quotations

In the data we present below interviewees have been grouped together in an effort to protect anonymity. Table 5 provides more information on the categories used:

<table>
<thead>
<tr>
<th>Category</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Health</td>
<td>participants working in public health in Rosetown PCT / LA</td>
</tr>
<tr>
<td>Local Authority</td>
<td>elected members and participants working in the local authority, in posts other than public health.</td>
</tr>
<tr>
<td>Clinicians</td>
<td>participants employed in NHS Trusts, NHS Foundation Trusts, primary and secondary care.</td>
</tr>
<tr>
<td>Commissioners</td>
<td>participants with responsibility for commissioning public health services.</td>
</tr>
</tbody>
</table>

**Table 5: Participants by role in the English case study interviews**
5.2 The process of commissioning to reduce alcohol-related harm in our English case study site

Rosetown was an early implementer for HWBs and at the time the fieldwork began in March 2012 in Rosetown, transition arrangements were well underway in light of the anticipated transfer of responsibilities for public health to LAs and changes in the commissioning structures, including those to reduce alcohol related harms, and reduce maternal alcohol consumption.

Shadow working arrangements had been established and the Joint Strategic Needs Assessment (full reference withheld) was refreshed as the basis for a shared understanding of community needs and shared strategy during 2011. HWS operating on a non-statutory basis, co-produced Joint HWS in light of the JSNA, providing a high level framework for CCGs, NHS England and LA commissioning plans. Statutory HWS were set to become the vehicle by which councils exercised their lead role integrating the commissioning of health, social care and public health services (full reference withheld). HWB membership in Rosetown largely followed guidance set out by the DoH (206) and included the posts of:

- Chief Executive of local authority
- Leader of city council
- Director of Adult Services and Health
- Director of Finance and Resources
- Director of Children’s Services
- Director of Community Services
- Director of Public Health
- Chair and representatives of GP Commissioning Clinical Group
- Director of Regeneration and Employment
- Public Health Business and Resources Planning Manager
Healthwatch representative

Cabinet Member for Adult Health and Social Care

5.2.1 Health Commission

The intention of the Health Commission is to find ways to improve the health and well-being of the local population, and importantly to find innovative ways to do this, by improving access to high quality healthcare and assessing the current health profile of the city, including the impact of factors such as smoking, alcohol, and drug misuse on peoples wellbeing. The commission is focusing on a few key conditions, including obesity, diabetes, rehabilitation after a period of illness, living with one or more long term condition, and dementia.

5.2.2 Health Improvement and Better Lifestyles Sub-Committee

Reporting for all the separate strands of the Better Lifestyles Programme, as outlined in the Public Health White Paper and the Health and Social Care Act (2012) was brought together in the Health Improvement and Better Lifestyles Sub-Committee, established in June 2012. It was jointly chaired by the Cabinet Member for Adult Health and Social Care, and Chair of the local NHS Trust. The Group was responsible for overseeing an integrated programme of activity including alcohol, drugs, tobacco control, healthy weight, mental and sexual health.

5.2.3 Alcohol Strategy Group (ASG)

Supporting co-ordinated planning and operational delivery of alcohol related interventions, the Alcohol Strategy Group (ASG) brought together multi-disciplinary stakeholders from partner organisations, including Public Health leads, NHS primary and secondary care providers, the VCS and commissioners. The ASG generated ideas and priorities from the partnership before the detailed technical commissioning and procurement processes began.

Activities were informed by a combination of stakeholder consultation, local intelligence (service monitoring data for example), local and national policy directives, in which the
evidence-base is often embedded e.g. the NHS Outcomes Framework, PH Outcomes Framework (208-209) and evidence produced by the National Institute for Care Excellence (NICE). In this way, the ASG formed an important part of the planning and co-ordination of alcohol-related services and interventions by bringing together service providers with strategic leads in public health and commissioning managers who were responsible for integrated public health interventions, in light of the available evidence. Monitoring information about commissioned activities, which was available to commissioning managers in public health, could be circulated to members of the Alcohol Strategy Group to inform future plans.

5.2.4 Prioritisation process for the Health and Wellbeing Strategy (2012 – 2015)

During 2011, the HWB undertook a prioritisation process, to identify a small number of priorities, to reflect those health related issues causing greatest unmet need in the population. These were chosen ‘to reflect the responsibilities of the Board, the priorities set out in the JSNA and focus on the big issues on which it was felt the HWB could reasonably expect to facilitate a measurable outcome’ (reference withheld). The priorities identified were;

- Alcohol
- Cancer
- Mental Health
- Child Poverty

In addition, the HWB identified a cross-cutting overarching theme reflecting the life-course to address the impact these issues have on children and families in Rosetown. During 2013, the JSNA was undertaken and used to inform a review of the local Alcohol Strategy and refreshed HWS. As part of the process, work was carried out to obtain the views of community groups and stakeholders relating to the health, social and economic impact of alcohol, including on groups most at risk. For each of the issues identified, a summary report was developed as part of the prioritisation process. This examined scale and severity, local impact, possibility of change through local action, effects on reducing health inequalities, links with other priorities, locally or nationally. Alcohol continues to be prioritised as a risk

5.2.5 Rosetown Alcohol Strategy (2011 – 2014)

Rosetown has a history of partnership working to reduce alcohol related harms. The Alcohol Strategy (2011 – 2014) further developed a programme of activity across the key themes of prevention, treatment and control. The overall aim of the strategy was to prevent and reduce alcohol-related problems through partnership working and use the best available evidence of what works (reference withheld). The strategy aimed to address policy objectives outlined in the Marmot Review (15) in recognition of the strong correlation between areas experiencing the highest economic disadvantage and those worst affected by alcohol related hospital admissions (Rosetown PCT full reference withheld).

The key outcomes identified in the Alcohol Strategy (2011-2014: 19; full reference withheld) included;

1. changing knowledge, skills and attitudes towards alcohol;
2. creating safer drinking environments;
3. supporting individual needs;
4. support for children, young people and parents in need;
5. reducing the availability and affordability of alcohol.

It was felt that a focus on outcome four would strengthen an area of the strategy which was considered to be less developed. The deliberate focus on the impact of alcohol on children and families fits with the principles of the HWB to address inequality at the outset of life (Rosetown HWS Briefing Paper full reference withheld). This aligns with the recommendations of The Marmot Report (15), which suggests that it is a matter of social justice that every child should be given the best start in life, and that society needs to address the social gradient in children’s access to positive early experiences. This choice, to focus on an under-developed cross-cutting area to reduce alcohol-related harms, is significant to the findings we cover later.
A pathway of activity was identified to achieve the following outcomes;

- improved education and guidance of families and practitioners re. harmful drinking in pregnancy;
- improved screening, identification and referral of those drinking at harmful levels;
- improved support for those continuing to drink at harmful levels in the ante-natal and post-natal period.

Two multi-agency workshops held in early 2012 invited local stakeholders to identify programmes, and interventions which support a reduction in maternal alcohol consumption in pregnancy. Following the workshops, a summary of main tasks was pulled together to form an action plan to guide implementation of the HWS, as shown below in Table 6.

<table>
<thead>
<tr>
<th>Tasks</th>
<th>Actions</th>
</tr>
</thead>
</table>
| Improve guidance and education      | Insight work developed to understand women’s motivations, barriers, beliefs etc. about drinking in pregnancy.  
                                          Insight work developed to understand midwives’ experience, knowledge and beliefs about supporting women re. alcohol use during pregnancy.  
                                          Research proposals developed by local university looking at familial and partner influences; benchmarking practice; risk stratification models.  
                                          Social marketing campaign in development, targeted demographic will cover at risk population. |
| Expected Outcomes (evidence and measures) | Improved understanding of what motivates local population to reduce / abstain from alcohol during pregnancy.  
                                          Improved understanding of current practice in how women / families are advised and supported about alcohol use in pregnancy.  
                                          Subsequent development of campaign and educational resources based upon triggers provided by Insight that are responsive to local population. |
| Tasks                              | Actions                                                                                           |
| Improved identification and screening | Pending meeting to discuss current and future practice with Rosetown Maternity Hospital  
                                          Literature review completed re. screening tools.  
                                          Alcohol Outreach Team to focus on families with aligned KPI’s. |
| Expected Outcomes (evidence and measures) | Benchmark current practice.  
                                          Development of alcohol content in ante-natal programme.  
                                          Development of screening tool to identify those women drinking above recommended limits.  
                                          Development of risk stratification model. |

Table 6: Tasks designed to reduce maternal alcohol consumption and expected outcomes in Rosetown
5.2.6 Commissioning of Insight work on maternal alcohol consumption – the commissioning process we followed

In order to meet the objectives outlined above, Rosetown PCT (as was then) commissioned an independent market research agency to undertake interviews with women and midwives. This is the process our case study partners requested that we follow. Rosetown has an established Insight Team based in Public Health, which takes responsibility for commissioning Insight work. A service evaluation brief (full reference withheld) was devised by a senior executive in the Insight Team, to be carried out according to the Healthy Foundations segmentation approach. The project was planned to be undertaken in partnership with Rosetown Hospital, as the local provider of maternity services (hereafter referred to as the Maternity Hospital). Its stated intention was ‘to inform the (then) PCT’s alcohol in pregnancy service improvement strategy which ultimately aims to reduce the number of women who drink alcohol during pregnancy’ (full reference withheld).

5.2.6.1 The planned Insight work.

Details of the Insight fieldwork and recruitment methods are provided below in Table 7. The work was to be carried under the Market Research Society code of conduct (210).

<table>
<thead>
<tr>
<th>Number of interviews</th>
<th>Who</th>
<th>Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>Midwives</td>
<td>Views on supporting women during pregnancy who drink alcohol, perceived motivations of the women. Identify their own training needs, and service development requirements, views on potential interventions</td>
</tr>
<tr>
<td>24 (4 focus groups)</td>
<td>Women aged 18 – 44 planning to become pregnant</td>
<td>Motivations, barriers and beliefs about drinking in pregnancy.</td>
</tr>
<tr>
<td>20</td>
<td>Women who are pregnant and are drinking alcohol</td>
<td></td>
</tr>
<tr>
<td>18 (6 triad groups)</td>
<td>Recent mothers who drank alcohol during pregnancy</td>
<td></td>
</tr>
</tbody>
</table>

Table 7: Insight work planned by the market research organisation commissioned to undertake the work in Rosetown
5.3 Findings - what evidence is used by whom and for what purpose?

For each commissioning cycle, precisely who is involved will be different. Below (Figure 5) illustrates the systems and structures involved in commissioning services to reduce alcohol-related harms in Rosetown. Parts of this diagram are teased out in the sections that follow. The commissioning process was not immediately apparent or straightforward in the way that this final account makes it appear. No-one person knew the ‘whole story’, or had been with the process the whole time, so what follows below is a construction compiled from various accounts of how things happened.

![Diagram: Evidence flow in Rosetown](image)

**Figure 5: To show how evidence enters and flows in Rosetown**

The data shows that a wide range of information, intelligence, data, statistics, local knowledge, etc. was called ‘evidence’ and was reported as being pulled in the organisational units concerned from diverse local, national and international sources by stakeholders in the case study site. Figure 5 (above) illustrates the potential evidence entry points in Rosetown, including evidence relating to alcohol use in pregnancy.
To simplify this view and to focus on the main sets of stakeholders involved, Figure 6 extracts and simplifies the process by which our case study site reached the point of commissioning the insight work.
Figure 6: To show a simplified version of the main stakeholders and process involved in deciding to commission Insight work to reduce maternal alcohol consumption.

Our entry to the process starts with the Joint Strategic Needs Assessment, as the HWB declined to be observed as they were in transitionary arrangements (although they take part in the interviews). Discussions about the nature and implications of the evidence took place in the Strategic Alcohol Group, where statistics, monitoring data and anecdotal feedback from NHS service providers were presented and debated alongside epidemiological data from Public Health, research findings commissioned from local universities and national guidelines. Representatives from the CCG and HWB attended these strategic alcohol meetings, although formal feedback from them was rarely observed during the time fieldwork was undertaken. Some key stakeholders, such as maternity providers were not represented at these meetings, during the fieldwork observations. This was significant as the meetings provide an opportunity for commissioners and providers to come together to inform, plan, coordinate and monitor activity to reduce alcohol related harm. It was also noteworthy, that the commissioning process for the insight research appeared to be separate from, and not well
integrated into, the strategic planning structures for alcohol. For example, the draft evaluation briefing document was not circulated for comment.

5.3.1 Evidence use in the Joint Strategic Needs Assessment (JSNA)

Figure 5 (above) illustrates that the process is cyclical. The research team entered in order to study a particular commissioning process, however, this piece of work was situated within a well-established and diverse body of commissioned work to address alcohol-related harms. In writing this report we had to make a choice where to begin the story. We begin with the way the strategic document (the JSNA) summarises and embed the latest evidence base in the process to help commissioners identify pressing needs.

The JSNA in Rosetown is recognised as a key document (evidence entry point) which pulls together (inter)national research evidence, local epidemiological data, identifies priorities, trends and areas on which to focus activity to reduce health inequalities and inform strategic planning:

“We’ve got the JSNA and the annual report every year, so that’s the first set of evidence that we use, erm, in terms of health inequalities and all the things that we need to concentrate on, so we set our priorities based on that, and I just think the weight of data that we have, that is important”. (LA 38)

It was hoped that the JSNA would be seen as a ‘living document’ which would evolve and change over time as new intelligence became available. To support this, the ECSS Rosetown PCT and the ECSS Rosetown City Council developed a web-based system to enable partner agencies and stakeholders to access information about health and social care needs across the area. The Public Health team were seen as playing a central role in this process:

“Public Health lead on the, you know, the JSNA for the city and its public health, definitely, they are absolutely the most crucial lynchpin for evidence-based information.” (Commissioner 3)

5.3.1.1 The Insight Team – developing actionable messages.

The Department of Health (2006) developed a Healthy Foundations Lifestyle Segmentation Model of the adult population of England to capture a range of attitudinal, psychological and environmental drivers of health-related behaviours to inform local and national health
improvement activities. This work is carried out by the Insight team. Alongside colleagues in Public Health who “crunch all the raw data and provide an overview”, (Comm3), the Insight team present themselves as an integral part of the commissioning process in terms of designing and developing ‘actionable outputs’:

“The epidemiology team […] so they do the overview […] we do the more sort of detailed understanding of characteristics, so people profiles, where they are and so on in a particular area [….] none of us could do what we do without each other because we have to work collectively, in terms of the raw data and then refining, and then the detail, and then the marketing, in terms of actionable outputs. So it’s quite a streamlined process in terms of the way we work.” (Public Health 36)

The ‘people profiles’ referred to in this quotation, are gathered using Mosaic Public Sector Profiler [212], a socio-economic classification tool that uses over 400 data indicators to classify the UK population into 15 groups and 69 Types. The local Mosaic profile and assigned characteristics of these groups are used to identify particular cohorts in highly defined geographical areas with specific behaviours, attitudes and lifestyles Targeted research is undertaken with these groups to help design and develop local public health interventions, including social marketing campaigns. This localised approach seems to be particularly valued in light of some of the perceived drawbacks of published research identified by some interviewees:

“What comes out gives you some guideline, it [research] doesn’t give you the specifics of how you apply that to a commissioned piece of work or a service specification, so you know, it’s up to us to go away and really think well, what does that actually mean to us when we’re designing this piece of work”. (Public Health 37)

Whilst it was clear that research evidence informed, (and was embedded in), strategic documents (policy, strategy statements, JSNAs) to set strategic organisational priorities, by identifying the nature, location, prevalence, co-related factors and possibly trends within a problem issue – at the level of commissioning (operationalising those priorities) research evidence seemed less useful. Knowledge managers in particular emphasised that different
kinds of evidence are needed in the local commissioning process of public health interventions:

“Because one of the things that is increasingly apparent around evidence commissioning, is that evidence for commissioning is less likely to appear in your sort of peer review materials. Which are all very good and they’re very nice and, will probably tell you what you need to know if you’re interested in a particular treatment, or a clinical issue, but aren’t very good when it comes to detailing how you might design a service. What sort of outcomes you should reasonably expect, how you’re going to measure the performance of a service, what you might include in the service spec. and that sort of material.” (NHS participant 4)

It is unclear if research evidence would be able to answer these questions, and at the point where commissioning decisions are made, commissioners find it challenging to identify what to do to address the problems which have been so carefully identified. The shift from knowledge to action is difficult. Participants suggest that when deciding on which interventions to commission, decision makers tend to request a different type of information:

“[..] what you almost want to know is, what’s the organisation that is comparable with you elsewhere in the country up to? What have they found out? And commissioners are very, very keen on that idea, they don’t want to be outliers, they don’t want to do anything particularly unusual that’s [not] been done elsewhere. And I think part of that’s because commissioning as a framework, they’re always acutely aware that there may be some legal comeback if they get it wrong.” (NHS participant 4)

Solutions (actionable messages) that are tried and tested and largely risk averse seem most favoured. However, learning from other areas’ public health activity itself has limitations, the sites that provide the exemplars have to be a ‘good match’. Rosetown members describe their position as unique. Anecdotally, ‘we are different here’ or ‘that wouldn’t work here’ is often heard. There may be reasons for thinking that particular solutions will not work, if local configurations are very different or the scale of the problem requires a different policy (as opposed to service) intervention. For example Rosetown has significantly higher alcohol-related hospital admissions and mortality rates than the UK average. The tension between having the ‘same’ problems, but being simultaneously ‘different’ is illustrated in the quote below:
“Because we’re just different from, we are the same, but we have a lot more issues I think than some places. Like, you know, somewhere down south is maybe doing a piece of work on this, it would probably, might look quite different to what it’s saying in [Rosetown]. Yes, so it wouldn’t work looking at somebody in another area, it’s not the same problem. And the kind of like prevalence about alcohol and stuff, isn’t the same here, it’s a real unique issue.” (LA participant 3).

Research evidence of proven interventions produced in very different locations are viewed sceptically for these reasons. Commissioners primarily want to know how any intervention will work in their location, with their people, at that time. In this way local Insight is seen as important to inform the development of realistic, acceptable public health messages in light of unclear or ‘cloudy’ evidence. This was important given concerns that alcohol and pregnancy are emotive issues.

“So Insight would be really important I think, involving women in pregnancy or pre-pregnancy in that discussion […] because, […], what we need to consider is if you give a message that is completely unachievable, do you then kind of increase the guilt, and you know, anxiety levels of women in pregnancy, and what does that do? So is there a message that is more acceptable? So you know, I think taking a whole range of views might be more important than the evidence because I think the evidence is so cloudy at the moment.” (Public Health 37)

In this way, women’s involvement in determining ‘appropriate’ messages was seen as important and Insight appears to provide the mechanism to access these views. Whilst Insight work seems to be embedded in the public health planning processes in Rosetown, it was not without its critics. Some had questions about its scientific rigour:

“Some of the weaknesses of the Insight work is that it’s a bit black box at times. It’s a bit unclear how the process is working to do the groupings, to do the segmentation, some of the leaps that are made in developing the hypotheses I think, well I know, that academic social scientists kind of like throw their hands up and say ‘well that’s not very good science.’” (Public Health 34)

Another interviewee recognised that Insight provides a ‘rich source of understanding from local people’, but questioned the way findings from Insight appeared to be seen as more important than other kinds of evidence:
“I think we’ve almost gone the opposite way round I think in the PCT […], the Insight work is seen as very, very important, which it is, but it’s not more important than other things […] sometimes I think of the tail wagging the dog […] something which is immediate and erm that’s very sexy at the moment doing the erm Healthy Foundations Segmentation and everybody’s kind of social marketing is flavour of the month and […] I wouldn’t say it wasn’t good, because it is good, and it’s very compelling […] and sometimes it’s quite hard to read academic research and I think some people find it very inaccessible so that needs to be taken into consideration as well.” (LA 4).

Findings from Insight work are presented in an accessible, user friendly format, with clear messages about what can be done, which stands in stark contrast to the perception of academic research as somewhat inaccessible and difficult to read. These comments shed light on the importance of presentational style with thought given to targeting messages for particular audiences.

The appeal of the Insight work was that it provided actionable messages, helping commissioners decide what to do to address the issues identified. However some doubt remains over what the Insight work has actually achieved and this critique allows us to see a level of local evidence that appears to be missing from consideration. The Insight model values the take-up and recognition (by the target audience of the key messages i.e. excessive drinking in pregnancy is harmful). As one participant says:

“This is one of the figures we’re most sort of proud of. About three quarters agreed that the adverts were aimed at people like me, and they made me more confident knowing about cancer victims.” (example given by LA 3 from a previous campaign).

However, this does not always provide information on the impact of commissioned interventions that relate directly to strategic priorities identified in the earlier stages of the commissioning process, e.g. has a social marketing campaign made pregnant women not only more aware of the risk of maternal alcohol consumption but has it also reduced their drinking in pregnancy and the risks associated with this (e.g. low birth weight, FASD)? There is no feedback or evaluation data to illustrate the impact of the insight work on health outcomes. As a consequence, some knowledge managers highlighted a need for more specific service
evaluations that research longer term effects and health outcomes, rather than relying upon one approach:

“Certainly seeing what impacts and what effects is important: has updating different services increased following on from this [intervention] and what are the outcomes longer term, have things improved?” (LA 2).

5.3.2 Packaging the evidence and appealing to the audience

The need to ‘package’ messages appropriately appears to apply at both national and local level. There was recognition that having robust scientific arguments is important, but they may not always be the most persuasive influence:

“I think that having a robust scientific argument helps, but it isn’t sort of the whole story, erm er. My early learning on that about twenty years ago I was trying to get [...] some money to [...] continue a community project and erm er we took our report to the Board of the [...] Health Authority Board [...], setting out what were kind of like the advantages were and what we’d achieved erm but [...] what swung it was bringing in the children’s choir who sang to them for five minutes”. (Public Health 34)

The above example highlights some of the tensions between the potential power of academic, reasoned ‘scientific’ argument and emotional calls to action, which appear to have different effects:

“It isn’t just the science that’s influencing decision making [...] It is recognising what different places have got different receptiveness to you know more or less academic approaches [...] science and its rigour doesn’t work in lots of places [...] It’s a blend of the two, I think there’s a lot of science behind what we do, because we are at base scientists, but there’s plenty of evidence in Rosetown of doing things which connect with people in a different way [...] on a much more emotional level.” (Public Health 34 emphasis added)
Other interviewees referred to the ‘compelling’ nature of different kinds of public health evidence. For example, public health data on hospital admissions or alcohol related deaths which were described as ‘shocking’ appeared to focus people’s attention in different ways.

“Public health data there was very compelling because all of a sudden, we were looking at figures that were really shocking…hospital admissions and deaths.”
(Clinician 14)

There was understanding by this interviewee that presenting tables of written figures might not provide most impact to local and national stakeholders, including Ministers and policy makers at national level. During a meeting where he was invited to give evidence to a Health Select Committee on alcohol-related harm, this clinician chose to illustrate potential health outcomes using pictures of babies from the local paper. His experience in clinical practice seemed to provide a powerful impetus:

“I remember the death of a 27 year old woman from liver failure, caused consternation and shock in the unit because we’d never seen it before. We couldn’t understand how this had happened, but that was the first of many.” (Clinician 14)

These examples highlight the diversity of ‘evidence’ in circulation at any given time, and the importance of interpreting and packaging information for maximum impact on its intended recipients, in a way that prompts action. The potential audience for public health evidence is changing, given LA’s ‘new’ responsibilities for public health. In light of the need for public accountability, elected members are considered important stakeholders, who have different sets of interests, and may require different approaches:

“We do know that erm elected members have particular interests and particular constituencies, and er they are they’re very swayed by erm storytelling, so I’m not saying that storytelling isn’t necessarily evidence based, but erm I think it’s an interesting mixture about how much in future we use the hard evidence base and how much we use, that kind of er, more sort of you know qualitative or storytelling type of stuff.” (Public Health 33)

This suggests the skills and expertise of public health specialists moving forward will need to include the ability to adapt to their changing environment to ensure evidence is heard and understood and presented in a way which maximises its potential use.
“I think it’s a real skill to be able to present the [research] evidence to the right people, but present it in a way that they understand and motivates them to, er, take it on board and do something with it […] any longer than two pages and people switch off.” (Public Health 35)

This same interviewee later commented when preparing papers for the HWB on the need to ‘keep it simple, and clear, no jargon’. Another respondent stated that it was important to keep the message ‘short and snappy’. The ability to be concise and make a persuasive case using plain language appeared to be valuable skills. Certain members of the knowledge management team had a reputation for being able to do just that, and they often became the person who was approached to search out and collate evidence. So whilst the organisation creates knowledge management roles, it is the agency of the people who fill them that makes the role effective. However, reliance upon one-or-two people may suggest a person-dependent system rather than robust organisational provision to fulfil these tasks:

“This somebody will phone, somebody will email, quite often you’ll get a conversation as a preface by, I’ve been told by such and such that you’re the man to talk to.” (NHS 4)

5.3.3 Blending evidence

A number of interviewees in different roles (Public Health leads, health professionals, managers and commissioners) recognised the importance of blending ‘hard’ evidence with ‘softer’ intelligence to take account of the preferences of some stakeholders, including elected members, who may draw on different sources of localised knowledge to public health professionals:

“I use the experience that I’ve got of actual people because I know what’s working and what isn’t working and how people live that I meet every day in my ward and in the surgeries and where I live and the people that live with me”. (LA 38)

The day to day contact that elected members have with their local constituents was seen as an important channel of feedback and communication. A related point was made by a clinical manager when asked whether research always holds the best solutions. S/he recognised that whilst evidence based research was important, professional expertise and tacit knowledge gained through clinical experience also has its place:
“…we will take account of that [research] as well as what we know anecdotally and from experience and knowledge of our own population so obviously research has a part and you know that’s what we’ve been doing over the last few decades isn’t it, using evidence based research and that is seen as the gold standard of the moment but is there a place for other things. I mean you know sometimes you can’t say why you know things can you, […], there’s something about that, whether it be intuition or experientially saying ‘but in my experience’ you know.” (Clinician 2)

Commissioners with responsibility for public health seemed to value a mix of evidence and recognised the importance of bringing different sources together to inform decision making:

“We have great evidence and we have fabulous evidence, we don’t bring it together in one, so that for me is around some small anecdotal information could feed into something very important. We don’t bring in very small snippets. We seem to have very strategic overarching information, but there’s not a combination between qualitative and quantitative and I think we do need that.” (Commissioner 3)

This raises questions about how this ‘anecdotal’ evidence, tacit knowledge and intuitive experience is captured and fed in to strategic planning discussions, given its potential value. It also highlights the challenges of inclusive, evidence informed decision making processes which take account of the diverse range of available evidence without privileging one set of interests over others. It requires an open, inclusive approach which values difference, however, talking across the purchaser-provider split make be more difficult.

There was this recognition of the value and importance of open, honest dialogue with stakeholders, participants believed that the tensions and complexities of managing sensitive negotiations across the purchaser-provider split between commissioners and service providers made this difficult:

“I think if you’ve got all the sort of high level decision makers round the table, you need to be able to have those open and frank discussions and whether you can do that in the same way when you’ve got potentially people at the table whose jobs will be affected by those decisions would make it untenable at that time”. (Public Health 35)
5.3.4 A backdrop of political influence

One interviewee was clear that evidence “first and foremost” should form the basis of “all that is commissioned”. Whilst she felt it was important to take account of the changing need and changing demographics in the population, she noted that politics also came in to play:

“I think also, and perhaps this will happen, you know, it will happen more now we’re in a Local Authority arena, is there’s a political element, I suppose, to what’s commissioned. And it’s understanding that better, erm, and balancing that against all those other factors, evidence, need and being a bit savvy, I suppose, around, erm, negotiating all those different areas.” (Public Health 35 emphasis added)

In addition, there was recognition from this interviewee that, ultimately, local political sensitivities can shape services:

“I would probably suggest that some things are allowed to continue, maybe with a weaker evidence base, because politically it might be quite sensitive to withdraw services. So it’s a constant, erm, balancing act really about, erm (pause) where the evidence is, but also with the politics in the background.” (Public Health 35 emphasis added)

5.3.4.1 Senior local political support.

Research participants acknowledged the benefits of having senior level strategic support and buy-in from politicians and elected members so that alcohol remained a high profile Public Health issue for the LA. During fieldwork, a senior local political official was observed making clear public commitments to tackle alcohol-related harms. Investment in the public health post of strategic lead for alcohol had been protected at a time of efficiency savings and squeezed budgets. An existing member of public health staff had been moved to cover these responsibilities when the previous post holder left.

Rosetown has a history of evidence-based commissioning and a national reputation for high profile research around alcohol. This has allowed the site to make significant contributions to national debates and health guidelines. This leading national role influences local commissioning practices and sets the framework for local health priorities and interventions to address these priorities. However, ironically, this does not always make it easy for local
commissioners to explore new avenues for public health interventions when this risks upsetting the national avenues paved by local heroes:

“.. one of the challenges for [Rosetown] has always been, and particularly around alcohol, there are a number of, I describe them as national pillars […] and these are big services, people on NICE groups, people contributing to the national understanding of this, but from a commissioning point of view, you wouldn’t want to be a commissioner because you’d have to sort of really play with the diplomacy around how to get a whole system working, when certain points in the system are irremovable.” (NHS participant 1).

This suggests that even when national guidance and evidence is informed by local research, and has local senior support, it is still not always easy to ‘get-it-work’ to inform local commissioning decisions. Something in the process by which it is turned into guidance or national policy distances it from local need:

“…and it’s [national guidance] very much developed on the basis of local data [from Rosetown] and knowledge and that sort of stuff. But in a way, it’s got nothing to do with the local area […] the funding has inevitably come from regions and the centre. The projects have been born out of what local areas tell us is relevant and interesting and necessary. And then the product becomes something that goes back into the centre, turns into policy and then gets pushed down to deliver as sort of guidance.” (NHS participant 1).

5.3.4.2 The choice of case study process.

There was nothing straightforward about the choice of case study process, on one level, the choice appears rational,

“We looked at our own strategy, and there’s stuff in there around women and pregnancy and we felt, well actually, that is one area where very little in our strategy is being delivered.” (Public Health 37)

However, selecting ‘reducing maternal alcohol consumption’ was more complicated than simply the desire to rationally develop a service or intervention. It simultaneously brought
together a number of issues facing practitioners to offer a practical focus. It was a pragmatic decision by senior Public Health managers to try and ‘get a grip on something’ which could be delivered in one or two years, in recognition of the continuing uncertainty facing public health and the potential to ‘get the Health and Wellbeing Board up and running’. These decisions emerged amidst questions about the role and responsibilities of the newly formed HWB:

“Apart from kind of a stamp of approval, imprimatur or whatever, what does the Health and Wellbeing Board do? [...] I suppose the crucial thing is how the Health and Wellbeing Board develops from now on, and how involved it’s going to be, and how hands-on.” (Public Health 33)

Other interviewees in public health shared the idea of using the HWS as a mechanism to proactively focus on specific actions to reduce maternal alcohol consumption, which could provide ‘added value’, whilst being seen to ‘do something’ and engage a wide range of stakeholders in the process:

“The idea behind the Health and Wellbeing Strategy is obviously to improve health in the city, but in this first year, our prime goal is, 1) to do something that looks sensible and 2) get some engagement with it from different bits of the system.” (Public Health 34)

In yet another way the choice to focus on women and pregnancy was interesting. Whilst it fits neatly with the HWS cross-cutting theme of children, young people and families, it was difficult to show robust evidence of need (i.e. as identified by the JSNA), as there were identified gaps in local intelligence (no collated routine data capture) – the focus was based on an assumption of need and an extrapolation that if the general levels of alcohol consumption in the population were rising, then it followed that some of those drinking problematically would be pregnant women. There is some research evidence that suggests that the opposite may be true – that pregnancy is a teachable moment, when women change their behaviours and (even if only temporarily) adopt a healthier lifestyle (i.e. in this case consume less alcohol) (125).

“We felt that given the levels of need we had in the population generally around alcohol misuse, some of that must be transferring over to the pregnant population.
But we weren’t able to support that by looking at the local intelligence from our maternity services.” (Public Health 35 – emphasis added in italics)

This observation echoes national research findings which show limited understanding of levels of alcohol-related harm in pregnancy, leading to a call for improved data collection and activities to increase awareness of the risks of drinking in pregnancy among women and with midwives (13, 148). This particular research article (the Morleo et al 2011 paper (148)) was mentioned by one commissioner as instrumental in her choice to focus on reducing maternal alcohol consumption. This illustrates that through individual agency research evidence can be directly pulled into commissioning decisions, and that even reasonably strategic decisions can be driven by assumptions and not hard data and research evidence.

5.3.5 Understanding gaps in routine data capture and missing local evidence

It is worth taking time to explore reasons for the gaps in the data regarding the prevalence and scale of alcohol consumption in pregnancy, as it highlights the dilemmas faced by our commissioners and providers and the need to commissioning work in this area. One knowledge manager suggests that frontline staff do not value or prioritise the recording of routine data because they misunderstand its purpose and role in informing service development and therefore they see it only as an additional chore:

“...I think there is a bit of a disconnect really between commissioners and what managers expect from services, and actually what’s delivered on the ground [...] It’s kind of getting them to understand the process of why you ask questions and what they would need to consider if they were doing [commissioning]. And I think by the end of it, particularly for the practice nurses, they did kind of say, ‘oh I kind of see why you ask these stupid questions now, you know’. ‘Why do we want to know what the ethnicity is, why do we want to know all those other kind of things we’re doing on the frontline.’ When they’re delivering the service or a clinic, they just go, ‘oh it’s just another box to tick.’” (LA 2)

However, in talking to frontline managers, despite maternal alcohol consumption being identified as a priority for commissioners, maternity service providers noted that they were
not asked to collect, collate or return relevant data to commissioners to inform their decision making, as shown in the following quotation:

“They [commissioners] are not asking us for alcohol consumption. So actually, they’re not asking us for it, so that tells its own story, doesn’t it? […] If we were getting some direction, if they asked us for it, we’re collecting that, and we could do more about let’s make it meaningful with the questions of ‘so what’s occasional mean’, but we’re not being asked for that, for us, we just record it, and it sits there, we don’t do anything else with that.” (Clinician 2 50)

Interestingly, the service provider felt that this data should belong to the commissioners rather than being data they could proactively act upon themselves. So, across the different parts of the system knowledge managers would value the information, but cannot request it, maternity service providers do collect it, but do not send it to commissioners. There is clearly a level of disconnect.

The notable perceived absence of anyone with power and influence ‘banging the drum’ about alcohol use in pregnancy suggests that there may be differing priorities driving maternity service providers. This raises questions about the public health roles and responsibilities of specialist secondary care providers, and about how public health intelligence from different parts of the system is gathered and used. Given the difficulties of identifying the effects of harmful alcohol use in babies, except in the small number of cases where FAS is diagnosed, it highlights the need for shared, co-ordinated data recording and monitoring systems. The importance of using monitoring data, despite its acknowledged limitations, was recognised by both commissioners and service providers, but in practice this seemed difficult to achieve across partners.

5.3.6 Using evidence at the frontline

Despite commissioning work to explore why evidence use at the frontline was patchy (the Insight work), participants already had views about what was happening. This helps us to understand why local research was undertaken despite a plentiful evidence base outlining barriers to evidence use at the point of care delivery. A senior practitioner reinforced
midwives’ willingness to address alcohol issues, but identified conflicting guidelines as problematic:

“We already ask the screening question and we already give advice. I think we can step up the information we give around alcohol and the dangers but we need more information about that to be able to give that.” (Clinician 2)

Whilst it is true that the lack of clear evidence hampers midwives’ efforts to provide clear unequivocal advice to women, it is unlikely that it is the only reason. Managers, clinicians and commissioners reported a range of explanations for health professionals’ apparent reluctance to address alcohol issues. Some clinical staff believed that data collection was not prioritised by midwives because of the tyranny of small numbers i.e. insufficient numbers of women presenting at maternity services to show significant evidence of the harmful effects of alcohol on babies:

“It’s not something they [maternity hospital] perceive as a real issue, I don’t think […] Well if they’re not seeing enough, I think the idea that you’re seeing lots of drunk mothers giving birth to deformed babies, it probably isn’t happening on a scale like that […] I don’t think they’re seeing huge numbers, erm, there’s nobody who is banging the drum.” (Clinician 43)

The social context, described by one clinician as ‘incredibly powerful’ was considered to have an impact on healthcare professionals who are reluctant to be seen to ‘lecture’ people:

“It’s something that we’re not, nurses and doctors, haven’t traditionally been very good at, asking about alcohol, and therefore probably not as good at picking up and labelling alcohol related diagnosis […] It’s just typical British awkwardness, and it’s just like, well, where are we going with this? And it’s like the nanny state and I don’t want to be boring and I don’t want to lecture.” (Clinician 43)

Drinking in pregnancy may conflict with professionals’ own values or conversely their drinking behaviours and may result in them feeling hypocritical questioning what right they have to ask women, let alone challenge them. Drawing on her experience of smoking cessation, one interviewee felt that ‘lecturing’ women was viewed negatively as it was seen to jeopardise the practitioner’s professional relationship with the woman:
“A lot of the health visitors and midwives that I did (smoking cessation) training with said it has an effect on the relationship they have with that mum. Because it’s like I’m lecturing them, and you know “you shouldn’t be smoking”.” (Clinician 44)

If the woman did not return for further care, then any influence or support that the midwife might have provided would be lost to the woman and asking the difficult question around alcohol consumption was not worth risking this for.

“It’s not an easy discussion you’re having anyway, and you certainly want that woman to come back.” (Clinician 2)

The recognition shown by interviewees of the sensitivities of discussing alcohol, smoking and domestic abuse, and the parallels drawn between them, may indicate there is scope to address multiple risky behaviours, by providing training for health professionals which may result in increased confidence across the board to raise difficult issues. These comments suggest there is some way to go before discussions about alcohol are embedded in routine care:

“Midwives are in society just like everybody else […] I don’t think we’re there with it [alcohol] yet. I think we’ve still got work to do…” (Clinician 2 emphasis added)

The following comment by an experienced health professional identifies the challenges that commissioning organisations (and national bodies who synthesise evidence) face in trying to influence the everyday practice of service providers, even where the evidence-base is well established:

“… but we’ve actually had two sets of recommendations, and they’re [midwives are] still not doing it…” (Clinician 40)

This suggests that although training, clear guidelines and fear of damaging the therapeutic relationships are factors that affect the used of evidence at the front line, other factors are also at work, perhaps resistance to imposed change. We explore some of these issues below.
5.3.7 Other implications of a contested evidence base

The evidence about the effects of drinking alcohol in pregnancy is unclear and contradictory and professional guidance about what is ‘safe’ to drink varies:

“Because of our current evidence, any woman might say ‘well, it’s OK to have a glass or whatever’ and I think that’s confusing for women.” (Public Health 37)

Women and health professionals may be unclear about what current guidance recommends about unit measurements and be aware of published research which indicates the beneficial effects of small amounts of alcohol (135). This makes alcohol more ‘complex’ than tobacco for example in terms of public health messages, as there is clear unambiguous evidence that all smoking is bad.

This lack of clear evidence about alcohol consumption in pregnancy, led some participants to express concerns about the possibilities of developing consistent messages for women, as ‘getting people to make behaviour changes relies on clear, simple information about what to do’ (Public Health 37). The same interviewee highlighted the wider social implications of alcohol related harm in families (where there is more robust evidence) providing a rationale for early intervention to reduce drinking:

“If there’s not very clear evidence, I would suggest that, you know, erring on the side of caution in pregnancy might be a good thing, but you know the evidence around drinking in pregnancy is not just about the impact on the foetus, although that’s a major impact, it’s also the impact on the family.” (Public Health 37)

Some participants suggested that the ultimate reason for not asking the awkward questions was that midwives did not want to hear the answer. Hearing that a woman has a problematic relationship with alcohol while pregnant, places the onus of professional responsibility on the midwife to do something about this, yet, there were only few onward referral services as residential places were limited (11 places).

“Midwives were very reluctant to talk to women about this because, A: they don’t know how to talk about it to them and, B: they don’t know what to offer, in terms of services afterwards.” (academic participant 5).
A small number of interviewees (commissioners and providers) did appear willing to challenge national guidance in England on pregnancy and alcohol as its changing nature was felt to be unclear and unhelpful to women and midwives, and to suggest abstinence during pregnancy:

“I feel very strongly we should be saying zero tolerance and we should be saying that, but it keeps changing about whether it’s a glass a week, two glasses a week, and that muddies the water for women, what’s one glass for me might be a different glass to you.” (Clinician 2)

The risk of this approach is that precautionary messages about drinking in pregnancy do not stand up to evidence-based scrutiny and they may be seen as a protective, value-laden, moral judgements (163), which are open to challenge especially if they are at odds with national or international guidelines. From the perspective of this study, it is curious that local research is commissioned (the insight work) to replicate a plentiful evidence base on the barriers to evidence use at the frontline, especially when the quotations above illustrate that the commissioners and other key stakeholders anticipated (and largely seemed to already know) the barriers that would be identified.

5.3.8 Imposed and challenged evidence

Hunter 1996 argues that the imposition of evidence-informed practice may be simply a way of driving imposed change on professional practice, to reduce professional autonomy and the discretion that professional practitioners’ may exercise in their practice. The extent to which health care /public health activities are centrally driven and how much room there is for local discretion and negotiation is mentioned by participants:

“I’m not sure about other organisations and how they approach it, but from an NHS perspective, sometimes a lot of the evidence, or then what happens as a result of the evidence, can be centrally driven. So you get your guidance, you get your directive and you just, you have to do it type of thing […] so it’s top down.” (Public Health 35)
However when asked, one NHS clinical manager indicated that even ‘top down’ messages were not adopted unquestioningly in her Trust. “We do comply with most NICE guidance but we don’t comply with every bit of it.” (Clinician). This indicates a willingness to challenge evidence, including national or international guidance, particularly where it appears to not ‘fit’ with the local population or where locally based research is available:

“All absolutely we do challenge evidence here and we don’t always go with what it says because we’ll have done our own evidence around our own cohorts of women so often now I’ll say ‘where did we get that from?’ and […] we did our own research around it and actually this is what we’ve shown here for Rosetown maternity hospital, I know this is what national guidance is telling us or international guidance or research but actually when we’ve compared that with what we do that actually doesn’t fit for our population […] so we challenge research in that way.” (Clinician 2)

The Trust in question was a large specialist teaching hospital, which was presented as an organisation willing to question existing practices and change policies and procedures for the benefit of patients. Sometimes lively debates between senior colleagues were reported to precede decisions about the implementation of changes in policy or procedure, especially where disagreements occurred. One of the senior clinicians took on the role of disseminating research evidence as part of his role, effectively paving the way for operational changes ‘on the ground’ – further evidence of a person dependent system for ensuring research utilisation at the front line:

“I think an understanding or having seen it first hand, that evidence base work does make a difference… I think you need to have an environment where you can challenge and champion evidence”. (Public Health 37)

Being part of an environment where using research was part of everyday interaction, and had shown positive benefits, seemed to help it become expected and normalised.

5.3.9 Evidence champions – trusting the person, trusting the evidence

Our findings show that it is easier to secure evidence uptake if a champion or team of champions with sufficient power, credibility or ‘clout’ introduces the evidence, discusses its
implications and ‘push’ evidence based practice and decision-making. This may be especially important where significant changes in practice are required or where staffing resources are particularly stretched:

“It’s generally you know a conversation or if some evidence is we’ve then changed a guideline because of it, he may be involved in saying, “I’ll tell you why we’ve changed this guideline, that sort of thing.” (Clinician 2)

Having an understanding of the importance of effective communication and visionary staff in pivotal positions to explain any changes which are being implemented has been shown to help adoption [72], so this bridging role seems critical to oiling the wheels of successful change management. In Rosetown it was not always clinicians who fulfilled this role, nor did it only apply to practice. A ‘research positive’ approach by a proactive chair in a key organisational position (senior decision-maker) was considered able to open doors to research being introduced and used:

“He’s [the Chair] very engaged with new evidence, new research, to support future practice, and sometimes having those ambassadors on board at that high level, really does, you know, push that agenda forward. It’s having some champions, I suppose, isn’t it?” (Clinician 2)

The ability of powerful individuals to effect change is demonstrated in the following quotation from a senior NHS leader who understands that different drivers and incentives can lead academics and service providers down different paths. He saw the benefits and tensions of bringing them together and use evidence to address public health issues:

“So yes, so you’ve got this University Institute, I’ve been very keen to bring that interconnection closely with the public health colleagues particularly, to get the insight from the University, with University people trying to work side by side with the commissioners […] They have to sit next to a commissioner to see how the research might be of benefit and value, even though, as you know, there’s a tension between people wanting to do world class research etc, on the one hand, and […] working with the commissioners on this year and next year, rather than, you know, ten years ahead […] So as a way of trying to encourage the commissioners to use academic literature, background, insight, and get academics to focus on how their
work might actually have impact, which they need to do for their Brownie points.”

(Commissioner 42)

Understanding of the research process, the range of evidence available and the different reward systems in operation in different settings, as well as familiarity with the context in which research evidence may be applied, and the potential interests involved was seen as helpful in other ways. Critical appraisal skills in assessing the quality of different kinds of research evidence were recognised as valuable, and as skills that could be acquired:

“You need to make a judgement of that research; [...] and if you’ve got skills in the organisation to do that then you ought to be getting robust research which actually erm is er going to erm which you can rely on, which you can trust and I suppose it comes down to trust doesn’t it, it’s trusting the research, [...] it’s really difficult with individuals unless it’s someone you’ve known for a long time and you trust [them].”

(LA 4)

Trust and reputation featured in a number of ways for commissioners and providers in their assessment of research validity, and the source of evidence was important in helping them determine its credibility. Clinicians appeared to rate as trustworthy evidence produced by other clinicians (21) or their representative body, as well as ‘reputable’ national evidence providers like NICE. In Rosetown, the added benefits of having local consultants involved in the production of NICE guidelines, were recognised as placing local providers ‘ahead of the game’ in some ways:

“We’re very privileged in Rosetown in that a lot of our consultants actually sit on a lot of the NICE guidelines panels and things like that, so we are often very aware of what’s happening nationally before it comes out, we’re almost one step ahead.”

(Clinician 2)

This ‘ownership’ places an onus on these organisations to identify and disseminate up-to-date, credible evidence, but also suggests they have considerable power to influence opinion among their followers, especially where they are known locally. NICE was not the only organisation identified in this way, and providers listed others they use, including online resources such as Map of Medicine pathways:
“…it’s an online resource, there’s a clinical group of people that produce it. Erm, but one of them is one of our partners, so I know that it’s, […] about being reputable, isn’t it? And knowing that, you know, so generally if it comes through NICE, or from the Medical, Medicines Management Team, erm, you know, or through the CCG or the Local Medical Council, people that you know, that it’s reputable, those sort of people I think.” (Clinician 41)

While supporting the use of Map of Medicine, this interviewee felt that there was no substitute for personal experience when it came to implementing ‘evidence-based medicine’, admitting that ‘I’m always happier when I’ve tried it and I know that it does work’. (Clinician 41 emphasis added)

However, even where local clinicians, with substantial expertise, were involved in the development of national guidelines, for instance, there were no guarantees that they would necessarily be in a position to inform local practice, especially where these challenged traditions, and routine practices:

“You’ve got to have the clinical and research expertise that gives you the credibility to say what you think, and even then sometimes it can be not, not as respected I think, and I think that is a big problem, because if it’s conflicting with what has been planned before they came in the room, then you’re perceived as a bit of a pain…..” (Clinician 1 – emphasis added)

Taken together, this suggests that there are numerous factors influencing the take-up and use of evidence, including the way it is presented, who presents it, to whom, in what setting and who is present at the time, so to a certain extent, the use of evidence is a person-dependent system, reliant on the interpersonal relationships, values, ideas and opportunities available in a context at any given moment. Evidence use depends on the willingness of busy practitioners to seek out the evidence, find time to appraise its value and relevance, discuss and make choices about its implications, and use their power and influence to effect change, as noted by an interviewee working in primary care:

“You have to have the time to read the evidence, and then it depends […], if you’ve got the time and the head space to implement the changes. Because it’s often you revert back to type, you know, if you’ve not got the time to […] assimilate and take the bits that you really think are appropriate. And then you have time to set up
educational sessions and impart that on to everybody else. And everybody else has
time to reflect on it and you have time to reflect to make sure it’s happening.”
(Clinician 41)

This quotation illustrates that evidence-informed changes do not simply happen but that
considerable effort is required to implement clinical and organisational changes ‘behind the
scenes’, actively supporting their implementation and monitoring their continuation. This, in
itself, places increasing pressure on practitioners’ workloads.

5.3.10 Financial pressures

The reality of being part of an LA facing large reductions in budgets, and the uncertainty
about the long term future of public health funding made forward planning challenging in the
face of competing priorities and influenced commissioning choices. There was anticipation
that by the end of 2014, the council was potentially facing budget cuts of up to 52% on the
previous year, with further reductions likely as a result of changes in the national formulae
for allocations, away from a focus on tackling socioeconomic disadvantage, towards
supporting health and social care for elderly populations.

Instead of holding out for the prospect of large scale investment, there was recognition of the
need for a different approach, influencing and persuading others in the organisation of the
benefits of shifting spending upstream into prevention and early intervention. This suggests
scope to make use of the evidence base about cost effectiveness to inform public health
decisions, although this interviewee was under no illusions about the challenges this
presented as money got ‘tighter’:

“But with only 18 months of guaranteed funding, we don’t know what’s going to
happen to public health funds after 2015. Having big plans isn’t probably sensible at
the moment […] The majority of our money is tied up in clinical contracts, and err,
it’s not going to be easy to extricate ourselves from those even if we wanted to. I
think the scope for changing how the money’s spent isn’t, […] about wholesale shift
in how public health resources are spent. It’s more about how we persuade the rest of
the organisation, how we shift, you know, other spend upstream but that’s going to be
more and more difficult […] I don’t think anybody’s got the capacity, or has the
confidence in the long term budget to make big plans for investment […] Money’s so tight and likely to get tighter”. (Public Health 49)

5.3.11 Using evidence in commissioning across a purchaser-provider split

NHS organisations providing antenatal and maternity services fully acknowledged the role they had to play in promoting public health, acknowledged that there was work to do on ‘both sides’ to build connections, and indicated they would appreciate opportunities to proactively engage with Public Health commissioners.

“There’s something around identifying where maternity and neonates, where we sit in the whole big public health of [Rosetown] so there’s work on both sides, what would be useful is to have some information from public health.” (Clinician 50)

However, as noted earlier sitting round a table, commissioners with potential providers can be seen to create a conflict of interests (see section 5.3.3). Yet, given that CCGs and LAs will be making commissioning decisions which could have profound implications on the entire health and social care economy in a given geographical area, a degree of co-ordination seems imperative. The challenging logistics of influencing the contracting negotiations of other organisations are clear, as shown in the following quotation:

“When the contract’s with another organisation, or when it’s a national contract, it’s much more difficult then, isn’t it, to put in extra requirements […] and then we’re not part of […] a lot of those discussions and negotiations go on when we’re not there.” (Public Health 49)

This suggests that using the contractual lever offered by commissioning to secure precisely the services commissioners know are needed is not always a possibility. This bears out earlier research which is critical of commissioning as a mechanism for securing services across partners (211). Contracts may well go ahead with little or no tailoring to meet the needs identified by local evidence. The importance of having conversational spaces, ideally face to face, to influence delivery, then becomes obvious, in light of the limited contractual levers available (50, 53, 72, 85).
“You can only influence, that’s why you’ve got to work with them [Foundation Trusts].” (Commissioner 52)

Despite its appearance as a hard contractual lever, commissioners were clear that the success of commissioning still rested on soft negotiation and influencing skills. These discussions and relational factors are not a circumvention of the correct commissioning process, but a key mechanism to secure co-ordination, and practical input. The ability to build trusting and credible interpersonal relationships has been shown as key in facilitating ongoing connections between all stakeholders (20). Our data casts doubt on the possibility of achieving agreed public health provision across the purchaser-provider split.

5.3.12 Changing structures – a new focus for public health?

Participants expressed concern that, at the moment, what was needed was a sense of long-term stability and a clear indication of funding moving forwards, to allow planning to be realistic. It is debatable whether the desired period of stability will ever come about, in the short-term, at least, maybe what is needed is the ability to respond continuously to change and learn, and adjust incrementally. In the absence of certainty about planning and pessimism about future funding in the short term, senior public health figures were considering focusing their efforts and attention upstream. Their belief was that more change would be possible by influencing national policy:

“I think if I was thinking of radical change in public health, I would probably go back to policy more than commissioning and contracting […] I think what we’re going to do is, just about manage to keep the system going […] it’s about managing, about keeping services going, rather than saying we can invest in a whole range of totally new ideas.” (Public Health 49)

This was markedly different from the observations made by the same interviewee in her first interview, when she commented:

“It’s a bit of a waste of time challenging national policy at the moment you know, it’s not really going to be particularly effective, and actually the thing we can do in Rosetown is do our own thing, do it our own way and do the best we can do […] and
you know, take note of national strategy, but you know we’ll try and do it better ourselves, not much point in just haranguing the government, because that isn’t very useful.” (Public Health 5)

The reasons for this marked change in view is difficult to gauge, but seemed to be part of the pessimism about not having sufficient resources to innovate locally to impact significantly on health outcomes. It was discussed earlier that the scale of public sectors reforms and the economic downscaling had created increased workloads and job insecurity for our participants; here we begin to see the impact on commissioning and planning and the very focus of public health activity. The quotation implies that with limited resources directing these at changing policy (and therefore the wider determinants of health) is a better use of those resources than trying to focus on local intervention to effect behaviour change.

5.4 A stalled commissioning process.

In practice, we did not get to see this commissioning process from start to finish in live time as was our intention. The commissioned piece of work was delayed for a number of different reasons and we were unable to fully follow the process to its end. The Market Research Company had difficulty recruiting midwives, pregnant women and new mothers who reported drinking in pregnancy to take part. The findings from this commissioned work were due to be presented to local commissioners after our study ended. It was anticipated that this would include a practical set of recommendations which would guide future decision making and commissioning of interventions in Rosetown to address maternal alcohol consumption. We return to discuss alternative reasons for the delayed commissioning work in Chapter 7 where we reflect upon the process of co-creation.
6 The Delphi Process, BARS questionnaire and the national seminar

6.1 Introduction

The project design permitted an in-depth look at research utilisation in two case study sites (across two policy contexts). As what counts as evidence, and how it is used, is heavily contextually influenced, it was crucial that attempts were made to explore the transferability and fit of the case study findings in other contexts. In chapter 2 we discussed the idea of public health issues as ‘wicked problems’, where issues defy precise definition (e.g. poverty) and stakeholders hold varying opinions about the causes of problems (and therefore effective solution). These wicked problems may well take slightly different forms in different contexts and any solution is only ever partial and temporary as the complex and multi-factorial issues morph and rise again (e.g. to use an analogy, squeezing a balloon in one place simply shunts the air to make the balloon bleb-up elsewhere).

In the analysis and discussion of the findings from the case studies, we identified 10 frequent issues involved in identifying, weighting and using evidence (considering similarities as well as differences across the cases – nomothetic and idiographic data). Interestingly, whereas the issues were common, how they manifest themselves was subtly different and the actions taken to address them varied. To the same ‘problem’ different solutions worked in different places (perhaps even in the same place at different times). With no right-or-wrong definitions or ‘solutions’, these 10 issues can be considered ‘wicked problems’. They are listed in table 8 and informed the questions on the Delphi. We identified the ways in which the issues are typically, if temporarily, resolved in the case studies and used these to write behavioural anchors for each issue in a modified Delphi questionnaire. We included an 11th item to gather the views of respondents on co-creating research.
<table>
<thead>
<tr>
<th>Item</th>
<th>Wicked Issue</th>
<th>How this manifest itself in the case studies</th>
<th>Behavioural anchors (practical solns)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>What</strong> type of evidence is most useful?</td>
<td><em>Salience, trustworthiness and utility.</em> Evidence collected here and now versus evidence created at another time and place.</td>
<td>National evidence</td>
</tr>
<tr>
<td>5</td>
<td><strong>What</strong> is ‘valid knowledge’?</td>
<td><em>What ‘counts’.</em> Externally coded versus situated and tacit knowledge.</td>
<td>Practical experience</td>
</tr>
<tr>
<td>4</td>
<td>Is the evidence ready for use?</td>
<td><em>Tailoring and fitting the evidence.</em> Are the messages in the evidence clear?</td>
<td>Evidence speaks for itself</td>
</tr>
<tr>
<td>2</td>
<td><strong>Where</strong> do I find the most useful evidence?</td>
<td><em>Range of sources.</em> Few favourite sources versus wide sweeps of multiple sources.</td>
<td>One trusted and tested source</td>
</tr>
<tr>
<td>3</td>
<td><strong>How</strong> is the evidence mobilised? (and by whom)</td>
<td><em>Structure or agency.</em> Organisational systems or person dependent processes?</td>
<td>People</td>
</tr>
<tr>
<td>6</td>
<td><strong>Managerial mechanism</strong> Via which mechanism for securing evidence informed activity.</td>
<td>Commissioning (purchaser-provider split)</td>
<td>Joint planning (unified organisations)</td>
</tr>
<tr>
<td>8</td>
<td><strong>Where</strong> is the evidence mobilised?</td>
<td><em>Upstream or downstream focus.</em> Where should limited time and resources be focused?</td>
<td>Policy change</td>
</tr>
<tr>
<td>9</td>
<td>What are the <strong>contextual influences</strong>? What factors compete to shape the decision?</td>
<td><em>The role of competing forces.</em> What factors compete to inform the decision?</td>
<td>Research evidence</td>
</tr>
<tr>
<td>10</td>
<td><strong>Why</strong> is the evidence mobilised?</td>
<td><em>Aim and purpose of evidence-use.</em> Reasons for use / objectives, desired outcomes.</td>
<td>Health gains</td>
</tr>
</tbody>
</table>

Table 8: The wicked-issues behind the questionnaire construction
6.2 Delphi questionnaire (1st round)

6.2.1 The Delphi process - issue of the Delphi questionnaire

For a detailed description of the issue of the Delphi questionnaire see table 9. The first issue, despite being wide ranging, resulted in only 18 completed questionnaires (and 15 registrations for the national workshop issued at the same time). A second targeted approach issued personally to all alcohol LA leads across England and Scotland (with an entry to a prize draw) and also circulated more widely through social media generated 16 more responses (n=34). At the national workshop these 34 responses to the Delphi were used to illustrate the issues, and prompt discussion. Of the 15 workshop registrations, 10 delegates attended on the day. A second vote on the Delphi was taken at the workshop (n=10). As the numbers of the 2-stage Delphi (first-stage n=34 and second stage n=10, given the very small numbers we do not include them here. For interest the scores are presented in appendices 11 and 12. Appendix 11 shows the changes in perceived importance of the different items between votes one and two and Appendix 12 shows the changes in the overall scores on the different items.

In a further attempt to generate data on the transferability of the findings from the two case study sites, the questionnaire (as a stand-alone instrument) was issued more widely across the UK. A full description of the issue of the questionnaire can be found in table 9 below. This table also gives a timeline to show how the wider issue of the questionnaire followed the initial disappointing returns from the 2-stage Delphi process. Every respondent that completed the questionnaire was entered in a prize draw and the winner was drawn on 25th November 2013 after all the entries were verified. The winner of the prize draw was a respondent located in Scotland and received an iPodiD Touch 4th generation (identity withheld). Taken together these extensive efforts still only generated an additional 39 responses (34 + 39 = 73 completed single stage questionnaires in total). It is these 73 responses we use in our analysis below (unless otherwise stated). Care should be taken when interpreting these results as the numbers are small, but the characteristics of respondents are
identified, the importance they attached to each issue and the scores across the 9 point scale. Findings across respondents from different sectors are also tentatively compared.
Table 9: The issue process for the questionnaire and the invite to the national workshop

<table>
<thead>
<tr>
<th>Issue</th>
<th>Recipients</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delphi questionnaire and invitation to the national workshop sent by email (and through newsletters, networks, circulation lists, and websites of the national organisations) 22/08/13</td>
<td>All participants in the research 125 other local stakeholders identified through fieldwork The advisory board members In England: All English chairs of HWS and CCGs; Midwifery officers in the case study sites In Scotland: Chairs and clerks of licensing boards in Scotland; Councillors with a responsibility for alcohol Nationally: national and regional addiction charities; PHE and Health Scotland; NHSCC press; Association of the Directors of Public Health (ADPH); Local Government Association (LGA); SpR Public Health (BHPH); Voluntary Organisations Network North East (VONNE); the Institute for local governance; and Balance North East (regional alcohol office) for issue via their networks, newsletter and websites for wider reach.</td>
<td>By 21/10/13 18 questionnaires 15 workshop registrations (not including the research team)</td>
</tr>
<tr>
<td>Reminder sent 9/10/13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Telephone calls to all LAs in England and Scotland to identify local alcohol leads (August - October 2013)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal email invitation to the workshop and Delphi questionnaire Social media Prize draw of an iPod or Kindle for return of the Delphi (re-issued to all) 5/11/2013 National Dissemination Workshop</td>
<td>151 named leads for alcohol across the English and Scottish local authorities. Facebook, Twitter, Linked-in accounts of the research team members and of Fuse (the centre for translational research in public health (<a href="http://www.fuse.ac.uk">www.fuse.ac.uk</a>)</td>
<td>By 5/11/2013 34 responses 15 workshop registrations (not including research team) 10 external attendees on the day</td>
</tr>
<tr>
<td>Social media</td>
<td>Workshop attendees issued links to the Delphi questionnaire via their social media sites and circulation lists</td>
<td>An additional 39 questionnaires. 73 in total.</td>
</tr>
</tbody>
</table>

6.2.2 Sample characteristics
Respondents were spread across different sectors as follows: Public Health in LAs (24%); LA employees outside Public Health (18%); and representatives from voluntary and community organisations (18%). Due to the sampling procedure outlined above, most respondents were from the North East of England (52%), with 20% from Scotland and 11% from the North West. Small numbers of people responded from other regions, such as Yorkshire and the Humber, East, the East Midlands, the South East, the South West, Greater London and Northern Ireland (see figures 7 and 8 below).

Figure 7: Sector characteristics of respondents (n=73)
Nearly 31% of the respondents came from the case study sites (the North West 10.8% and Scotland 20%). It is likely that some of these respondents were participants in the study or had attended their local workshop and so they may have known of the findings in advance of filling in the questionnaire. Of the remaining respondents, 52.3% were from the North East (local to the University hosting the research). The remaining respondents (c. 17%) were from across the UK. Neither those responding from the North East, nor those respondents from other parts of the UK, will have had prior knowledge of the research findings, nor been part of the contexts in which the data were gathered. This suggests that more than two-thirds of the respondents were expressing opinions about how the findings applied in different contexts to those of the case study sites (c. 50 people).
6.3 Findings

6.3.1 Importance of Delphi issues

We offer this tentative descriptive analysis to illustrate the findings of the questionnaire, however the numbers are small and the sample is not representative of the views of commissioners in all contexts of the UK. First, we present the results for the perceived importance of each topic (Table 10), followed by the ratings on the BARS scale (Table 11).

Of the 10 items, seven were rated as ‘very important’ by the majority of respondents. The three items rated as somewhat important were issues: 3) whether people or systems and process ensure that evidence is drawn into the decision making (38.6%); and 6) whether a purchaser-provider split or joint planning makes it easier to secure evidence informed decisions (42.2%); 11) whether research should be produced for or with decision makers (32.5%). In addition items 6 and 11 received the highest ‘not important’ scores with 10.8% and 14.5% respectively. This suggests that respondents do not think that who or what draws evidence into the decision making, nor the way knowledge is produced (with or without them), nor the system in which this knowledge is used to make decisions (commissioning or planning) makes much difference to securing evidence informed interventions. This appears to contrast with the findings of the two case studies, which highlighted the importance of person dependent systems for evidence flows and, in Rosetown, the barriers for sharing evidence imposed by purchaser-provider split. The items considered ‘very important’ are directly related to the type of evidence that is used and what is it used for. The three items considered ‘most important’ are whether Public Health should focus on changing national policy or influence individual behaviour (63.9%), whether one trusted source or a variety of sources should be used (61.4%); and what level of evidence is most useful for Public Health decision-making: national or local evidence (62.7%).
<table>
<thead>
<tr>
<th>Q</th>
<th>Behavioural anchors</th>
<th>% of respondents (n=73):</th>
</tr>
</thead>
</table>
| 1 | I find national evidence most useful in my decision-making on Public Health issues | I find local data and information most useful in my decision-making on Public Health issues | Not Important 1.2%
Somewhat important 22.9%
Very important 62.7% |
| 2 | I typically go to one trusted source of evidence | I typically draw upon a wide variety of evidence sources | Not Important 0.0%
Somewhat important 26.5%
Very important 61.4% |
| 3 | It’s people that make sure evidence is drawn into decision-making in my organisation | It’s the organisational systems and processes that ensure evidence is drawn into decision-making in my organisation | Not Important 2.4%
Somewhat important 47.0%
Very important 38.6% |
| 4 | Mostly the evidence ‘speaks for itself’ | Mostly the evidence needs active interpretation to pull out key messages | Not Important 3.6%
Somewhat important 30.1%
Very important 54.2% |
| 5 | The most valuable knowledge comes from practical experience | The most valuable knowledge comes from robust academic research | Not Important 1.2%
Somewhat important 42.2%
Very important 44.6% |
| 6 | Commissioning across a purchaser-provider split makes it easier to secure evidence-informed interventions | Joint Planning across unified organisational arrangements makes it easier to secure evidence-informed interventions | Not Important 10.8%
Somewhat important 31.3%
Very important 42.2% |
| 7 | Public Health should be focussed on changing national policy | Public Health should be focussed on changing individual behaviour | Not Important 0.0%
Somewhat important 24.1%
Very important 63.9% |
| 8 | Research evidence best informs strategic planning | Research evidence best informs service delivery | Not Important 4.8%
Somewhat important 38.6%
Very important 43.4% |
| 9 | Research evidence ‘trumps’ politics | Politics ‘trump’ research evidence | Not Important 6.0%
Somewhat important 31.3%
Very important 50.6% |
| 10 | The health of the population is most important when making decisions | The economic well-being of the population is most important when making decisions | Not Important 3.6%
Somewhat important 22.9%
Very important 59.0% |
| 11 | Research evidence should be produced for me | Research evidence should be produced with me | Not Important 14.5%
Somewhat important 38.6%
Very important 32.5% |

Table 10: Importance of Delphi statements (n=73)

6.3.2 BARS rating for Delphi statements

Table 11 on the following page summarises the ratings on the BARS scale. To illustrate variability in the responses, the range of answers on each item is represented by a boxplot.
which shows the interquartile distances between answers. The thick vertical line in each box is the median, which divides the responses in two, with 50 per cent of the answers displayed on the left side of the line and 50 percent on the right. The left half of the box represents the 25 per cent of answers below the median, while the right half of the box shows the spread of the 25 percent of answers above the median. The outer lines on each side of the box highlight the next 25 percent of answers on each side and therefore show the full range of replies across the scale.

In interpreting Table 11 we note that no single behavioural anchor attracts a 100% score, indicating that respondents are pulled by both anchors. This illustrates that the anchors, although competing, represent viable solutions, and that overall no one anchor presents a definitive ‘solution’ to the wicked issue. In itself, this suggests that ‘correct solutions’ may only be finally identified in situ, not in abstract.

Some items e.g.: 1 utility of national vs. local evidence; 5 value of externally codified vs. situated knowledge; 7 the focus of Public Health – policy versus behaviour change; 8 (best use of research utilisation – strategic versus operational and; 9 what is most influential - research evidence or politics provide equal pulls on the respondents, giving an overall score on the median point. This suggests that in differing situations either anchor applies equally; it is literally not possible to decide between them.

Other items do suggest that one anchor may be slightly more appealing. Item 2 suggests an overall preference for drawing upon multiple sources of evidence; item 3 that people draw evidence into decision-making; 4 that evidence always need active interpretation; 6 that joint planning makes it easier to achieve evidence informed interventions; 10 that the health of the population is of most importance and 11 that respondents prefer evidence to be created with them. However, these preferences are not strong and there are differences across stakeholder groups we explore these differences in the next section.
I find national evidence most useful in my decision-making on Public Health issues

I find local data and information most useful in my decision-making on Public Health issues

I typically go to one trusted source of evidence

I typically draw upon a wide variety of evidence sources

It’s people that make sure evidence is drawn into decision-making in my organisation

It’s the organisational systems and processes that ensure evidence is drawn into decision making in my organisation

Mostly the evidence ‘speaks for itself’

Mostly the evidence needs active interpretation to pull out key messages

The most valuable knowledge comes from practical experience

The most valuable knowledge comes from robust academic research

Commissioning across a purchaser-provider split makes it easier to secure evidence-informed interventions

Joint Planning across unified organisational arrangements makes it easier to secure evidence-informed interventions

Public Health should be focussed on changing national policy

Public Health should be focussed on changing individual behaviour

Research evidence best informs strategic planning

Research evidence best informs service delivery

Research evidence ‘trumps’ politics

Politics ‘trump’ research evidence

The health of the population is most important when making decisions

The economic well-being of the population is most important when making decisions

Research evidence should be produced for me

Research evidence should be produced with me

Table 11: Results of Delphi questionnaire (1st round; n=73); interquartile range for each pair of statements (boxplots)
6.3.3 BARS ratings by sector

Figure 8 shows that in this small sample opinions vary across sectors respondents from some sectors showing a clear preference for one statement over the other, while other sectors are more divided in their opinions. Respondents working in the NHS have a stronger preference for academic research and also believe that research evidence trumps politics, while respondents from LAs put more emphasis on the value of practical experience. Academic respondents (not surprisingly) share NHS participants’ preference for academic research but feel more strongly about the usefulness of national evidence for Public Health decision-making. Contrary to this, LA respondents that work outside Public Health and respondents working in cross-sector partnerships (Other category) find that local data and information are more useful for these decisions. If these results were borne out in a larger sample, this might suggest challenges for research evidence use in the new health system with Public Health moving to LAs, if more emphasis is being placed on local data and practical experiences.

There are some interesting differences between LA respondents working in and outside Public Health: although both agree that practical experience is more valuable, those working outside Public Health also highlight the usefulness of local data and believe that research evidence (from these sources) will trump local politics. However, members from voluntary and community organisations in our sample disagree with this and argue that politics triumph over research evidence and highlight the importance of national evidence for decision making on Public Health interventions. Numbers are very small, but taken together this suggests that different types of evidence may be sought, valued and used across the organisations and sectors involved in public health – a story often anecdotally heard and supported by our case study findings.

On other issues, the findings are very mixed. For instance, respondents working in the NHS and LA are divided on whether people or organisational systems and processes draw in evidence. However, participants from academia, the voluntary sector and cross sector partnership agree that people are more important for drawing evidence into decision making processes. Also, views on the focus of public health (policy or changing individual behaviour), is more divided in the NHS and academia. In contrast, participants working in LAs, both inside and outside public health, and respondents form the voluntary sector prefer
an individual focus on changing unhealthy behaviours. This data reminds us that ‘sectors’ should not be viewed as unitary bodies; they are pluralistic entities, whose constituents have personal opinions, and where colleagues may only partially share opinions and that our numbers are too small to draw any firm conclusions from or make finer distinctions.

Overall, our tentative summary is that in the new system for public health, those who seek to use and mobilise research evidence need to take into account the preference of LAs for public health interventions that target individual behaviours and favour local data. The different opinions between sectors are summarised in Table 12 below while more details on these differences can be found in Figure 8. We offer these tables as illustrative of the data on the transferability of our findings on the use of evidence in commissioning decisions to other contexts, not as definitive statements on the spread of these views across contexts or sectors.

| NHS: Stronger preference for academic research, and believe that research evidence trumps politics | Academia: national evidence is more useful in decision making, slightly stronger preference for academic research |
| Local Authority-Public Health: Stronger preference for practical experience | VCS: politics trump evidence, national evidence is more useful in decision making |
| More divided on people vs. systems; and national policy vs. individual behaviour | More divided on national policy vs. individual behaviour |
| Local Authority (non Public Health): research evidence trumps politics; practical experience and local evidence provide more valuable knowledge. More divided people vs. systems | Other: practical experience and local evidence provide more valuable knowledge. More divided on national policy vs. individual behaviour; and strategic planning vs. service delivery |

Table 12: Differences in BARS ratings by sector
Figure 9: Results of the questionnaire by sectors (voluntary and community organisations, academia and other* (1st round; n=73).
(NB: The ‘Other’ category includes many cross-sector partnerships, such as local Alcohol and Drug Partnerships and Crime and Safety Partnerships.)

We carried out a Chi² of goodness-of-fit for each Delphi statement (See Table 13) which confirmed that the spread of responses, and the clustering of responses at certain points on the 9 point scale was unlikely to have happened by chance. The exception is for statement 9 - research trumps politics or the other way round ($\chi^2(8) = 14.411$, $p < .072$). These issues were selected for further discussion with participants in the national interactive workshop.

<table>
<thead>
<tr>
<th></th>
<th>Chi-Square</th>
<th>df</th>
<th>Asymp. Sig.</th>
</tr>
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<tbody>
<tr>
<td>national versus local evidence</td>
<td>32.411a</td>
<td>8</td>
<td>.000</td>
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<tr>
<td>one versus various sources</td>
<td>37.333b</td>
<td>7</td>
<td>.000</td>
</tr>
<tr>
<td>people versus systems</td>
<td>25.778b</td>
<td>7</td>
<td>.001</td>
</tr>
<tr>
<td>evidence speaks for itself</td>
<td>41.205c</td>
<td>6</td>
<td>.000</td>
</tr>
<tr>
<td>active interpretation</td>
<td></td>
<td></td>
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<tr>
<td>practical experience versus</td>
<td>88.877a</td>
<td>8</td>
<td>.000</td>
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<tr>
<td>academic research</td>
<td></td>
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<tr>
<td>purchaser-provider versus</td>
<td>41.789d</td>
<td>7</td>
<td>.000</td>
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<tr>
<td>joint planning</td>
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<tr>
<td>national policy versus</td>
<td>73.096a</td>
<td>8</td>
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<tr>
<td>individual behaviour</td>
<td></td>
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<tr>
<td>strategic planning versus</td>
<td>175.528e</td>
<td>6</td>
<td>.000</td>
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<tr>
<td>service delivery</td>
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<tr>
<td>research evidence versus</td>
<td>14.411a</td>
<td>8</td>
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<tr>
<td>politics</td>
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<td>population health versus</td>
<td>39.556b</td>
<td>7</td>
<td>.000</td>
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<tr>
<td>economic well-being</td>
<td></td>
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<tr>
<td>produced for versus</td>
<td>26.972c</td>
<td>6</td>
<td>.000</td>
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<tr>
<td>with me</td>
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**Table 13: Chi² test of goodness-of-fit for each Delphi statement**

### 6.4 National workshop

The case study findings, comments from the case study sites’ local feedback workshops, and the Delphi findings informed the programme for the national workshop. However, only 10 external participants attended, so we report the resultant discussion only briefly, and with caution. The 10 participants came from across the UK and worked in a range of sectors. Below we capture the main points of the discussion.
6.4.1 Evidence flows in Thistletown

First findings from the Scottish case study site were discussed. Participants were particularly concerned with the question whether the introduction of an additional public health objective for licensing in England would be beneficial given the experiences with this objective in the Scottish case study.

“We’ve spent time lobbying for health to be included as part of licensing objectives – it’s clearly not helpful. The people on Licensing Boards are not users of the night-time economy and are therefore influenced by anecdotes and stories, e.g.; claims that closing a nightclub earlier would cost 200 jobs. This can have a significant effect on the Board, although not logical.” (Note: The numbers attending the workshop were small and to preserve anonymity we do not identify the quotations in any way.)

It became clear that not everyone was aware that an over-provision statement did not apply generally but that a specific objection had to be made relating to each application. This raised debate about how practitioners use public health evidence in practical ways. Participants commented that it is preferable sometimes to go for conditions on the license rather than an outright objection based on health data, as a mid-ground solution. One participant suggested the use of cumulative impact policies, which put the onus on applicant to demonstrate the added value of their application worked better. Overall, participants agreed that a better fit of public health data would be an important prerequisite and that improved partnership working would be essential to make such an objective effective.

6.4.2 Debate around Rosetown

After the presentation of Rosetown findings, participants explored the role of values among professionals, who could use their contact with the public for a brief intervention:
“People expect screening questions about drinking and other sensitive topics: is it that the professionals have the taboos not the client?”

A representative from a regional alcohol charity explained that their research among local GPs highlighted that GPs were often reluctant to raise this issue with patients due to uncertainty about the availability of follow-up support and treatment services. This led to a discussion about unclear referral and service pathways for women identified as drinking in pregnancy, which was also reported as a problem in Rosetown.

“You won’t ask the question if you don’t know what to do with the answer. There is a lesson here from other services.”

Overall the discussion concluded that midwives might be the wrong person to raise the question about alcohol consumption in pregnancy. The first antenatal booking session at the end the first trimester of pregnancy could be too late with many women having continued their ‘normal’ drinking behaviour. Participants therefore discussed using more ‘upstream measures’ to engage women earlier in conversations about drinking during pregnancy. Educational and advertising campaigns were mentioned to enable people to make more informed choices. Persuasive communication theory was also mentioned and the value of using a role model (hero figure) to give the message, or someone ‘like me’ and ‘this is what happened to me’.

It was recognised by participants that working steadily on the issue of maternal alcohol consumption for a number of years may eventually have effects, similar to the smoking and 5-a-day fruit and vegetable campaigns. Behavioural changes need to be reinforced by changes in the wider environment alongside the provision of services. The advice was therefore to structure the environment at all levels in order to make it easier for people ‘to do the right thing’.
6.4.3 Debate around the findings from the Delphi first round

After the presentations on the case study findings, the results from the first Delphi round (N=34) were presented and discussed with the audience. Participants expressed surprise at the finding that respondents in LA believed more strongly that evidence trumps politics.

“I’m intrigued that the local authority (outside Public Health) people were saying that evidence trumps politics; I would have expected the opposite.”

The unexpected finding was explained in this way; that although the word ‘evidence’ is used, what is meant by that is different:

“Local authorities may stop seeing that politics does trump evidence and assume evidence is being used. Local authorities may think of evidence as what’s happening locally/practical experience.”

This triggered a discussion about the interpretation of the statements by respondents, and whether they answered from a ‘what is’ or ‘should be’ perspective reflecting either current experience or future desirability, which is a reasonable critique of the Delphi instrument as used here.

6.4.4 Debate around three ‘curious cases’ from the case studies

Three vignettes from the case studies were presented to highlight the complexities involved in using research evidence for decision making, and the wicked issues involved as outlined in table 10. Appendices 13-15: include the three vignettes used. The first case illustrated issues with data interpretation and the difficulties in showing casual relationships between local level hospital admissions data and premises selling alcohol in the locality due to off sales in neighbouring localities and ‘preloading’ at home. This issue was one picked-up by legal agents for applicants appealing the decision to refuse a license in an over-provided area and largely undermines the causal link between alcohol-related harm and overprovision (using geographical data) thus neutralises the power of the research evidence, largely neutering public health objections.
Participants considered times when the nature of evidence may permit it to trump politics and this sparked a debate about the role of public health. Participants also discussed the relationship between health and economic vibrancy with some suggesting that costs simply get shunted onto the NHS while others argued that economic vibrancy does not have to run counter to health objectives:

“So, what is public health? What is the greater good? Is it [overprovision] only a problem if the facilities are misused? If we all drank safely would the pubs still make money?”

It was stated that pubs are often be the safest place to drink (due to work across agencies e.g. police) and therefore licensing extensions of other trades and off-sales should be reviewed more carefully.

A comment was made by one alcohol lead that s/he received 8-10 requests per week for comments on licensing applications, of which only 1 in 10 were new. The other applications were extensions or modifications to existing trading, e.g., a kebab house asking for a licence, and the driver is extra profit. This participant also stressed that conditions on licences can be used to reduce overconsumption (by reducing availability). S/he also stated that it is if big supermarkets are challenged about their timings for selling alcohol: they will negotiate. In practice, participants had many practical ‘tips’ for using evidence is quite subtle ways.

The second example highlighted issues around routine data collection and lack of training for health professionals on data collection and usage. Participants recommended more training.

“This should be a mandatory lesson in SRE/PSHE curriculum, not science. We need evidence around the efficacy of PSHE, if not done people get their information from anywhere.”

However, participants argued that this should not be an excuse for not asking questions, as in some health provider settings the questions are asked without problem (with references being made to private medical practices):

“In private medical systems the questions are asked routinely without carrying a judgemental aura. This needs to be routinised in the public sector, plus made into a
consistent message in the first place. If necessary we need to develop a local message in place of the national message, because we have no clear evidence as there was for smoking.”

The third example highlighted issues in making national data fit for local purpose, immediately the lack of actionable messages was raised: ‘You go to conferences and are told the scale of the problem but not the solution’. Participants argued that actionable messages from national research would cut down the need for local research. However, other participants agreed that local evidence was necessary for priority setting and exploring the acceptability of potential interventions.

“There can be too much research on too many subjects, and too many guidelines, but the local work needs to be done to identify the top priorities.”

6.5 Discussion

Participants felt that including a 5th licensing objective for public health in England would only work if public health data provided a better fit with the local policy and legal framework and that improved partnership working would be important to achieve this. More generally, participants agreed that (national) messages need to be tailored to local needs and that identifying local allies was key for this. They recommended a pragmatic approach to data gathering, collation and submission: ‘don’t be a health purist’, but aim to win people over by using the data to tell the story, and provide actionable messages. This requires the use of a wider range of methods and sources, such as qualitative messages and tactical knowledge based on practical experience.

6.5.1 Participants’ ‘tips’ for using evidence

Based on the discussion of research utilisation in complex settings, participants concluded the following:
• That introducing a 5th licensing objective for public health does not provide a panacea solution in securing the use of public health data and intelligence in licensing decision-making.

• Don’t be a health purist but aim to win people over: public health evangelists are counter-productive, be pragmatic;

• Use the data to tell the story, present qualitative messages as well; this will also make public health people more approachable. If possible, use an influential local person;

• Identify local allies and tailor messages;

• Use actionable messages – ask the right questions of the evidence you have.

The above points are discussed more fully in the final chapter, in order to consider the pragmatic steps that public health commissioners and planners take to manage the competing demands on them and the needs of other stakeholders and the populations they serve,
7 The experience of co-creation

7.1 Introduction

Part of the overall aim (and objectives) of this study was to work in co-creation with our research participants, and research question 2 makes learning about co-creation an integral part of this study. In chapter 2 we outlined the promise of co-creation and the methodology we developed for this research project to work in co-creation with our case study partners in chapter 3 (the plan). Here we reflect upon what happened. We begin with a brief recap of some of the main points in the literature.

Some authors suggest that when academics and practitioners work together to co-create research, this enables partners to better understand the complexities each other faces, enhancing ownership and credibility of research and supporting implementation (34, 50). Working collaboratively however is not always easy to achieve (87) as researchers and practitioners often approach issues differently and bring different skills and expectations to partnerships (87). Factors that facilitate collaborative working include trust, communicative relationships, and having a shared focus (51, 87, 211). It is often the people involved and the working relationships developed (213) that are considered key to effective collaboration (54), whether senior leaders promote collaborative relationships and the large amount of time needed to develop strong partnerships are highlighted as potential barriers.

We will reflect on our experiences and those of our partners in applying the three main components of our co-creation methodology:

1. Enabling participants in each case study site to choose their own topic;

2. Involving participants as co-researchers in the project;

3. Jointly discussing and interpreting the research findings with participants.

How well did each element work and how useful were they in hindsight? Data was collected from the researchers’ reflective diaries and interviews with case study partners towards the end of fieldwork. After discussing the challenges and opportunities for each element, we will
discuss the impact of our co-creation efforts in both case study sites by reflecting on the changes that we and our partners have witnessed as a result of the collaboration process. This leads to a more general reflection at the end of the chapter on the challenges and future opportunities for researching in co-creation.

## 7.2 Co-creation approach 1: choice of topic

In our study, the choice of alcohol as a public health issue was predetermined in the study protocol, beyond this, the precise focus of the study was left loose, in the anticipation that this would give our participating sites more scope to mould the topic focus to meet their needs and that, ultimately, once entry had been negotiated, the focus would be more honed. This was only partially realised. In Thistletown the process case study we followed was specific and contained (evidence-use in the legal alcohol licensing process), however, in Rosetown the areas of commissioning to address alcohol related harms were extensive and honing down a contained commissioning process to follow in live time was a challenge. Most commissioning was already ongoing, out of our timescales and or recurring spend. However, the research team worked alongside partners to identify the precise focus they wished the research to take to ensure the process case study topic was timely and relevant to them (and to facilitate buy-in).

In Thistletown a number of meetings and discussions between case study partners and the research team took place between February 2012 and July 2012 (with email correspondence in-between) before it was decided that evidence use in alcohol licensing should be the focus. Further negotiations were then necessary to secure ‘buy-in’ and negotiate access to meetings with the LA and Licensing Board. Fieldwork began in September 2012, and first interviews took place in October 2012. Partners in Rosetown decided at a meeting in March 2012 that their topic choice was evidence use in reducing maternal alcohol consumption before, during and after pregnancy. This included improving guidance and education, identification and screening for alcohol (mis)use during pregnancy and improving access to alcohol services. We had built-in four months of research time to negotiate entry, discuss co-creation and agree an alcohol case study topic with our participants from the above it is possible to see that this was more involved than anticipated and needed more time. Although practitioners and
senior-decision-makers were involved in the writing of the research proposal and protocol and the research questions within it, they were not the same practitioners and decision-makers as our research participants. Our period of negotiated entry was spent ‘selling’ these ideas to a new set of collaborators and discussing how the research would work. Time was needed to let our research participants consider the ideas, consult with others and explore the practicalities of picking different case study topics.

Early meetings provided the researchers with contextual background to some of the relevant local alcohol issues, what agencies and organisations were involved and how these structures fitted together strategically. However, the extended period of negotiated entry in Thistletown (over several meetings across sectors) caused the researcher concerns regarding loss of fieldwork time and falling behind Rosetown. This meant potentially missed opportunities to share fieldwork experiences, amend topic guides, and interview questions, and to give and receive peer support.

Partners in both sites stated that the ability to choose the study topic differentiated this study from previous research studies they had participated in and was unfamiliar to them. In Thistletown, partners appreciated the opportunity to choose the topic, but found it challenging: “maybe one of the hardest bits” (Thistletown 1).

Despite being given a short one-page summary (see appendix 8), participants reported initial uncertainty about the expectations of them in relation to working in co-creation and the implications of choosing the topic. Some became frustrated by the time it took for the research to ‘begin’.

Some participants in Thistletown felt they would have valued more explanation and direction from the research team around topic choice early on and more information regarding the time commitment that involvement with the study would take. These are interesting learning points for the research team. From our perspective, we thought case study partners in the Thistletown understood our expectations of them (see Appendix 9) and we were cautious not to rush their decision making to ensure they reached a choice they were happy with.

“[Choosing the topic] was probably the most frustrating bit of it … we were brought in, you’re thinking, I don’t know what this is about. What is it we’re doing here? And
it was very nebulous and there was I suppose, a concern that, does this co-creation mean we’ve got to set it all up for you?...I think our frustrations were probably at the beginning, it seemed to take a long while to get off the ground, and partly that is because you are trying to co-create it, but that seemed like it was awfully vague for an awful long time.” (Thistletown 1),

In addition to this, involving the case study partners in early discussions (during the compilation of the application, long before funding), had the effect of building frustration at the time it takes for the application to go through review, funding, contracting, and ethical approval before fieldwork begins (and of course if the application is not successful then these efforts may come to nothing). As fieldwork progressed, we deliberated, as a research team, about whether, in both sites, we had been asked to highlight issues (and relationships) which were particularly difficult for case study partners to address themselves (handed a ‘loaded gun’). Tricky issues (e.g. about relationships between commissioners and the largest and most powerful provider), which everybody knew about, but did not feel able to voice themselves were shared in interviews. By ‘gifting’ this information to us in interviews the strained relationship also become our problem. It was now our data and part of the emergent findings to be fed-back in the joint interpretation meetings.

One participant hinted at this and claimed that they felt that co-creation process had given them licence to pick tricky issues:

“It may have influenced the topic choice because you’re more likely to pick something difficult with a co-creation approach. If we’d chosen something straightforward, it doesn’t test out how we work together with partners. With a tricky issue, it’s better to have a co-creation approach because you can move towards a better understanding through the process.” (Rosetown 37).

Our research engagement was being used tactically to lever and prompt improved working relationships. It was not simply Rosetown, but also Thistletown that picked a troublesome topic, where they currently felt at an impasse. They too used the research team to engage partners where previous relationships (and influencing) had been difficult.
In Rosetown, whilst the topic fitted the strategic priorities in the HWS (2013), decisions about the best approaches to take were complicated by changing commissioning arrangements underway in England and contested, contradictory evidence about ‘safe’ levels of drinking in pregnancy, and perhaps a troubled relationship across the purchaser-provider split.

In both sites, the topics chosen presented challenges to local stakeholders; ‘wicked’ problems, characterised by the involvement of multiple stakeholders, multi-disciplinary partnerships, complex inter-organisational and interpersonal relationships, and no easy solutions. In both sites, it seemed as if the participants and the research team took substantial risks engaging with each other to explore these thorny issues. For example, would it be possible to raise issues and use the research to influence future working relationships between stakeholders locally (action research), and if so, was there a risk that it could make relationships worse, and hamper the efforts to collect data, leaving all parties a loser?

Below we reflect more upon this and our ability to engage with wider partners in Thistletown, but not in Rosetown, where the powerful provider declined to engage in the alcohol strategy group and the joint interpretation meetings, and where the difficulties in recruiting midwives to take part in the commissioned research process that we followed (the Insight work) caused the process case study to stall.

7.3 Co-creation approach 2: participants as co-researchers

Participants were not only invited to choose the topic for the research but actively encouraged to become co-researchers in the project by shaping or adding research questions, suggesting respondents for interviews and observations and by conducting interviews and analysis themselves, if they so wished. Unfortunately, our partners in both case study sites did not engage actively with these opportunities. No suggestions were made for additional research questions (to add to and ‘piggy-back’ on the proposed data collection) and none of our partners took up the opportunity to becoming actively involved in the fieldwork. The lack of engagement of our partners in both case study sites as co-researchers raises questions about the sharing of roles in co-creation. Although we intended to share our researcher role with
participants, in practice a task division occurred between our role and theirs. Whilst our participants were very supportive in negotiating access to relevant stakeholders for the interviews and access to relevant decision making meetings for us to observe as researchers they perceived the conducting of fieldwork as the domain of the researchers. Our research participants expected us to carry out the research and discuss the progress and findings with them and were happy to act as commentators on the emergent findings, but not to take a more active role. Where interpretation was shared in the joint interpretation meetings there were several occasions were new insight was added. This points to potential barriers for working in co-creation based on different role expectations (85, 214) that might need to be clearly negotiated at the start of the research process to enable role sharing in practice. Participation may also be blocked by other factors (for example: skills-sets; time; and other resource barriers). Although the research was considered to be “very interesting”, the joint interpretation group in Rosetown was cancelled on three occasions. It is difficult to know why this was the case. It could simply be the inevitable result of a public health system being in transformation or that the topic was genuinely considered a low priority.

In both sites, the involvement of senior Public Health colleagues was critical to ensuring early buy-in from wider stakeholders. Senior management endorsement helped facilitate access to potential interviewees, snowball contacts, and legitimise access to relevant meetings. It also influenced the nature of our contacts, how we were seen, how the research was presented; by whom, when, and how we presented ourselves. (We say more of this below.)

Even with senior ‘buy-in’ and working in co-creation, there were still some places we did not get to see - our access to certain meetings was carefully managed. Some meetings the research team identified as potential sites to observe (e.g. HWB in England and the convening of the Board/Forum subgroup in Scotland), were rendered out of bounds. The reasons varied: some meetings had legal privilege and not open to anyone except members; others were meetings being held by new organisational groups and they were keen to focus on core activities in the early days; at others our access was simply declined. There are limits to the level of scrutiny participants are able and willing to allow themselves to be subject to.
7.4 Co-creation method 3: joint interpretation of findings

Finding time to take part in feedback and joint data interpretation meetings was also an issue for the participants:

“…it didn’t feel like a spotlight shone on you […] I think there are times when you’ve sort of gone ooh it involves more time than you initially expected […] this clearly has been a far more involved process of bringing people together, talking things through, reporting back etc. etc. and you know I don’t think I quite understood at the start quite the amount of time I don’t regret the amount of time but I don’t think I understood it at the start.” (Thistletown 2)

Different role expectations also came into play in the third element of our co-creation methodology, not only between researchers and partners but also between partners. For instance, despite Health and LAs in both sites having a strategic commitment to address alcohol related harm in both sites, there appeared to be a disconnect (or misunderstandings, or power struggles) between some partner organisations involved.

We faced a number of dilemmas as researchers. We had made a commitment to feedback our early findings, and recognised that some of these might be seen as contentious or controversial. We felt we had developed positive, trusting relationships with case study partners and did not want to disrupt these, or appear over-critical. However, not accurately reflecting back what we found jeopardised the integrity of the research process. The research team were being actively used as mediators. However, despite our concerns, when presented with interim findings in both the Thistletown and Rosetown, case study partners appeared to have expected them, embraced them, and both sites sought to make changes:

“There were comments in terms of our practice; I thought they were fair comments there did need to be more structured working together on it – yeah I am perfectly happy with that.” (Thistletown 2).

“That everybody needs to work differently to make this work, I think is a really positive thing to come out of it. And that we, hopefully, are all able to accept that and think, yes well let’s change on the basis of that.” (Thistletown 1).
The facilitated discussions in the joint interpretation meetings offered opportunities to contribute to a shared understanding of the systems and structures in place locally to respond and the accuracy of the findings was improved through this process:

“We were able to give you feedback and say, that bit’s not quite right, and then it changed and even when it doesn’t exactly match, we could see how you’d got to that point.” (Rosetown Public Health 37).

In Thistletown, there was recognition of the benefits of the considered approach taken by the researcher:

“You’ve been very good at that, and, erm, testing things out before you’re going to go wider. And err, these discussions and the organisation of the workshops, I think that’s been really positive. And that’s been part of what we will get out of this apart from the results, is just that process. So I think that’s been really good.” (Thistletown 1).

### 7.5 Impact of co-creation

Case study participants in both sites reported that involvement in the study had been beneficial (and some believed that the expectations around co-creation were clear):

“I have seen people feel very threatened by researchers, but they weren’t with this and you gave a clear explanation about co-creation and what it meant, and because of how the research team were, very hands-on, very approachable, very flexible, it worked well.” (Rosetown Public Health 37).

In both case study sites, difficult messages were accepted and confirmed (perhaps because these issues were already known to them (and this was the reason why the topic was selected in the first place - (in order for us to explicate them to other partners). However, the extent in which they were acted upon varied between our case studies.

In Rosetown, there was more ambivalence around perceived benefits, indicating that our efforts in co-creation had more limited success in terms of engaging all partners with an interest in reducing maternal alcohol consumption. Our reflection on this is it is part of the
feeling of being handed ‘loaded guns’ – both topics selected were selected in the hope that we might make headway in breaking down barriers. In Rosetown, as the research progressed, it became apparent that the gaps were too deep seated and not directly about the topics we were working on, but about strategic links between the organisations concerned. a. We were not able to engage with all stakeholders. In addition, in Rosetown the involvement of these multiple organisations undergoing re-organisation, and staffing changes mid-way through the study, left us without full access to them. Co-creation is limited in what it can achieve if not all partners will ‘play ball’.

“If part of the collaborative approach was to get partners to work together, it hasn’t worked, the whole piece of work feels a bit messy if I’m honest, disjointed.”

(Rosetown Public Health 45).

There is perhaps another agenda here – that we were being mobilised as trouble shooters – specifically to ‘sort out’ locally knotty issues. If partner organisations believed this to be true – then it perhaps reveals their unwillingness to be ‘sorted out’? This is an important point, that participants who did not join the research process at the beginning may have different views, which influenced buy-in. Being involved in the original planning may be a key event for co-creation. By being identified with ‘one-side’ at the start we were viewed suspiciously thereafter by the other parties.

There was a suggestion by this participant that Rosetown partners might have gained more value if a different topic had been selected. Other participants acknowledged that the timing of fieldwork during the transition of Public Health to LAs had hampered progress.

In Thistletown partners did feel that the process of working with the research team enabled them to designate specific time to address alcohol licensing, suggesting the process had enabled them to have the time and the space to think, and discuss issues with each other, that otherwise would not have happened (even though they often met at a number of different strategic meetings around other topics).

In Rosetown, participants were more limited in their ability to open up difficult discussions about what evidence was used, by whom and with what effects, because not all stakeholders chose to be present at these meetings, and any opportunities to build alternative
‘organisational bridges’, interpersonal links and forthright discussions were reduced by the constrains imposed by the purchaser-provider split. We may speculate on the reasons for this: these fora did not (yet) seem to exist; Rosetown were too much in transition with roles too new; or last (but not insignificantly) the purchaser-provider split made such meetings difficult, if not impossible. In Rosetown these conversations appeared to take place outside formalised fora and in smaller groups between representatives of particular organisations and the ‘gritty’ difficult business was done there. As the research progressed this encouraged us to think about where and when commissioning actually happens. It did not appear to be an event occurring at a set time and place. Often activity was going-on in-between the formal organisational spaces, and we did not get to observe this, so our accounts remain partial.

“Not just in the meetings, but outside meetings, it prompted a light bulb moment for some.” (Rosetown Public Health 37)

Participants in follow-up interviews in both sites expressed their appreciation of the joint interpretation and feedback meetings, as they stimulated discussions, which would not have taken place otherwise:

“I suppose we wouldn’t have had that discussion had you not pulled us all together (laughs), so to that extent, I suppose it helped us kind of articulate our thinking a bit really.” (Rosetown Public Health 33).

For other participants navigating new structures and job roles, their involvement in the research appears to have prompted them to reflect differently, and make proactive changes as a result of their participation. Reflecting on allocating roles and responsibilities in their own team, one interviewee decided:

“I think that’s exactly what I’m going to do now because you’ve made me think. There are areas, like alcohol, that we do need to link in to [name] you know, so this has been very mutually beneficial.” (Rosetown Commissioner 40)

In Thistletown, the joint-interpretation meetings did not only provide conversational spaces but also facilitated local changes in relationships and decision making:
“I believe this is an exemplary piece of work that may have real and practical implications for how we do things in [Thistletown].” (Thistletown 4 personal correspondence)

“I think that, erm dialogue, and particularly with the Board itself has become more constructive. And I think there is a better understanding of each other’s perspective, or we probably, we understood it before but maybe a greater willingness to take account of it in discussions. […] that’s why your research is so important, because if we think, actually if you did it differently, if you stick at it or we can now have a different relationship, it could be worthwhile, then that takes us forward.”

(Thistletown 1)

7.6 Did anything change in practice – instrumental outcomes of research utilisation and working in co-creation?

In Rosetown, there are few changes to report, partly because, at the time of writing, decisions have yet to be made following results of the Insight work commissioned (the case study process we were following). These will be influenced by substantial pressures on LA public health budgets. The NHS Trust providing maternity services are undertaking work to improve their data collection systems to enable better understanding of reported levels of drinking in pregnancy. Also, as mentioned above, despite our best efforts, we were less successful in facilitating collaborative partnerships between purchasers and providers, which may reflect current churn or signify wider challenges of working in these organisational arrangements.

In Thistletown, the researcher observed a number of specific, tangible outcomes, which may have resulted from this study. There are plans to address membership and operation of the Local Licensing Forum, to enable ‘more constructive conversations’ to take place (Thistletown 1). Increased partnership working among organisations was observed, which partners felt ‘would not have happened as quickly if it hadn’t been for this process’ (Thistletown 2, emphasis added). There was particular appreciation for ‘how willing and honest some colleagues had been in saying they hadn’t engaged as much as they should’ (Thistletown 3). There are also plans to appoint to a post, jointly funded by the Alcohol and

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Drug Partnership and Community Planning, someone that will support input of health evidence into the licensing process to directly address the gaps in the flow of evidence we identified. It is always difficult to directly attribute research efforts to specific outcomes - some case study partners felt that the need for this post had previously been identified. Maybe our efforts were simply levers to accelerate change (38, 217).

7.7 Reflections on co-creation from the research team perspective

Working in co-creation is not straightforward. It presents epistemological, methodological, and ethical challenges, and raises questions about truth, (re)presentation, and ethical difficulties of protecting participants’ anonymity and confidentiality during and after fieldwork. It also highlights the challenges of maintaining working relationships with stakeholders when difficult or sensitive issues are uncovered, which we had made a commitment to feed back through joint interpretation group meetings.

As observers in meetings, we chose whether, when and how we contributed, shared our reflections, ideas and thoughts, formally and informally. Inevitably our presence did affect proceedings in some ways, whether we adopted the role of ‘constructively clueless’ researcher advocated by (215), or made suggestions drawing upon personal/ professional skills, knowledge and expertise gathered from experience as practitioners and academics. There were times during fieldwork when these tensions were difficult to navigate and we were required to make on-the-spot judgement about our role and how the research should be undertaken. There were moments when participants asked questions about our perception of situations, or people. We risked inadvertently disclosing information by the questions we asked, how we framed them, and responses we made. We see these issues as integral to the process of all participatory approaches (81, 83, 89).

We learned a great deal from our research participants. Whilst we had ideas, research skills, and were ‘primed’ by the evidence-base - we were definitely not the experts. It is obvious that local knowledge, organisational memory and the tacit ‘feel’ for the work of commissioning and joint planning are not ‘added extras’ but core to the successful accomplishment of the role. As research agendas move forward more attention needs to be paid to how research evidence is actually used in practice, what factors influence this, what
other approaches are needed to complement this activity, and how researchers can be more helpful in all of this.

7.7.1 Co-creation as a long distance activity

Neither of our case study sites were local. Our work with them was carried out in field visits. Whilst we were able to build good relationships, we remained visitors and outsiders. This may be to our advantage in that we preserved the ability to see issues afresh, but we do feel that it limited our capacity to work in full co-creation. Being on-site, ‘rubbing shoulders’ with our participants and working locally in a more concerted way to create collaboration would have honed our approach. It is our ultimate reflection that to carry out co-creation in order to maximise the full benefits of the approach, the researcher needs to be on-site for an extended period of time. This suggests that co-creation might fit more easily with ethnographic approaches or via secondments between sectors.

In the final chapter, an overarching read-across the different findings is given. This analysis is tied back to the findings with examples from both cases. Both the contribution and limitations of the study are discussed and two-mid range (realist) theories are presented. Their capacity to explain the findings is considered.

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8 Discussion and concluding remarks

8.1 Preamble

This chapter is in three parts. The first part identifies the limitations of the study; the second section identifies the contribution made by this study and gives a high-level read across the findings in order to synthesise the various data streams to answer the overarching theoretical question: what works where, for whom, and under what conditions (169). Included in this section are two mid-range theories as the study’s unique contribution to knowledge. The final section outlines recommendations for practice, researchers and educators, and research funders and makes suggestions for further research. Care needs to be taken when interpreting the findings as this is a small study. We start with an explanation of the quantitative analysis conducted as part of this project, the challenges it faced and the format the quantitative analysis finally took, along with other limitations of the study.

8.2 Limitations of the study

8.2.1 Quantitative analysis – an aspiration too far?

We anticipated that data would be available to examine the overall performance of the case study site organisations (their quality), and that these data would be readily accessible. In fact this was not the case.

Extensive efforts were made to identify routine data sources that would allow us to address the quantitative component of the study. The quantitative measures of performance would have allowed us to see if there was any reason for considering our sites to be typical (or outliers) in what they were able to achieve, and therefore contextualise the qualitative data (ie we would know the standing of the organisations we were working with). Appendix 9 and 10 lay out in some detail the approaches we tried.

However, currently, there is a challenge when drawing out changes in performance over time because high level performance indicators for England have changed for both the NHS and LAs over the past five years including the organisations that were responsible for their
performance assessment. To explain: within England the quality indicators over the three performance frameworks (The NHS outcomes framework, Public Health framework and adult social care framework) are not consistent over time and it is currently unclear which indicators are relevant to the different commissioning organisations (HWBs, CCGs, LAs, etc). There are benchmarks for the NHS outcomes frameworks where NHS organisations can compare themselves to other organisations but access is restricted to NHS employees (www.nhscomparartors.nhs). This makes it hard for external researchers to obtain any objective (quantitative) measures of quality.

Statutory performance indicators are available for all local authority councils but they are not collated in any one area, nor are they reported consistently by councils. This reporting issue had two main implications for this project. Firstly, it is not straightforward to identify where they are reported. Second, and importantly, measurement between councils and possibly within councils is not standardised. This means that comparative data would be misleading (possibly explaining why collated information is not reported). Taken together this suggests that little or no national/local performance measures are readily available that would allow meaningful comparison between locations or indeed over time, to establish good measures of quality.

It may be possible to address these issues (i.e. identify, access, collect, clean and interrogate these data) but it would probably necessitate new primary data collection and be a substantive research project in its own right, which was beyond the scope of this project. Overall our attempted economic analysis highlights some very real quantitative information gaps.

Where it was possible, descriptive quantitative data is added to the case study chapters to contextualise the issues in the case study locations, and to support the findings. However, in Rosetown, routine data linking alcohol consumption and pregnancy is based on subject categories (e.g. drinks ‘occasionally’); is self-reported or not recorded at all(making a FOI request of little use). In Thistletown, the number of licences granted was recorded (on a case by case basis) but not collated. Requests made to ask for this data to be extracted were declined as the one practitioner involved had insufficient time to search all records. As part of our negotiated entry to Thistletown we were required to agree not to issue a FOI request on the LA with regards to its licensing data (again for capacity reasons). Appendices 9 and 10
report on the quantitative scoping work we undertook, the sources consulted and gives an overall, descriptive quantitative account of the substantive topics in the case study sites (licensing and alcohol use in pregnancy). We choose not to present some of the local and national data, as we balance this against the need to preserve the anonymity of the case sites. Most of the routine data compares the ‘core cities’ within the UK and comparative prevalence and trends over time. It is easy to identify locations form this data.

8.2.2 The challenges of comparative case study design

In-depth case studies permit deep examination of practice in situ, and the interplay between multiple factors in that context often in live time, to provide a realism (‘messiness’) and richness that controlled designs often do not. The advantage is that a plethora of data is revealed that could not have been exposed in other ways. We sampled our case study sites according to issues considered to be pivotal in shaping the use of evidence - organisational arrangements (commissioning versus joint planning) to compare how the issues played out in the different contexts.

‘Preventing alcohol-related harms’ was selected as the overarching cohering topic area, but, by allowing each site to select their own topic area (of most pressing concern, and fitting-in with their own strategic objectives), through working in co-creation, a gap opened between the two sites. When viewed traditionally the direct unit of comparison appears lost – in our findings it is impossible to say if any differences between the two sites was due to the organisational arrangements (commissioning versus joint planning) or the topic (maternal alcohol consumption versus alcohol licensing). However, in a realist design this direct (controlled) comparison between the sites is of less importance. What the prime focus is, is the interaction between what works, why, and under what conditions in looking at the use of evidence. We built an increasing understanding by looking at how evidence is used and what works in one site (and process) and then built upon or refuted this understanding by looking at what works across the second site. It was this iterative comparison that illuminated factors in the process of using evidence and the opportunities and constrains offered by different settings, not in the attempt to pin down the definitive causal pathways determining evidence use that our understanding and contribution lays.
There were ongoing challenges in the English context. The key stakeholders with whom we were working changed in the middle of the project as original members changed role (displaced). Often stakeholders would not be sure if they were part of the process as roles were changing and some practitioners were holding portfolios temporarily (caretaking) till the new structures (and roles) were established. Many staff were uncertain regarding their ongoing job security. When the commissioning process in Rosetown stalled (mid-way), we were left in a hiatus till there was movement (behind the scenes that we did not see). At this point, following the live process as was our intention, was thwarted and our data gathering became historical in nature.

8.2.3 Limited wider stakeholder evaluation

In following this design, we acknowledge that it is unlikely that all the findings will apply everywhere (truly generalisable) however, the opposite is also true. It is also unlikely that none of the findings will apply elsewhere (REF). Some will hold important and transferable messages for evidence use in other places (transferability). The key is to identify which findings are more context dependent (apply only locally) and which may be considered more context free (and therefore apply more widely).

Several steps were taken to verify and validate our case study findings, both within the case sites and to explore transferability to other contexts. In each case study site we held a final local workshop, to discuss findings, check our interpretation, and invite comments and interpretation. This ‘checked’ our findings with other local stakeholders including other commissioners and senior public health decisions-makers. These stakeholders were forthright in their comments and they helped us to understand the history of, reasons for, and significance of the findings. We did not proceed to the national workshop until the local sites were happy that our findings reflected how they understood the process. Through this process the accuracy of the case study findings were validated by a wider local audience.

Checking the results for transferable messages across contexts was more challenging. These efforts were not entirely successful. Table 9 (Chapter 6) speaks to our efforts to invite stakeholders to the national workshop and issue the two-stage Delphi process. Despite sending out approximately 1,000 questionnaires and phoning all PH departments / sections in all English local authorities and all licensing boards convenors in Scotland to invite them, and
all professional bodies and VCS organisations associated with the topic areas only 10 participants attended the ‘national’ workshop.

It is difficult to say why this is the case. Respondents gave different reasons for non-attendance: they were too busy to leave their desks (dealing with transitionary arrangements); that there was no money for training and development events; they were carrying additional portfolios of displaced staff; or they were uncertainty about how ‘taking time out from the day job’ would be perceived at a time of job insecurity, etc.). Poor attendance may also be due to research-overload or perhaps the lack of interest in the topic areas (although this did not seem to be the case).

However, the Delphi process was severely limited by this. Only 34 first-stage replies (before the workshop) and 10 second-stage votes (at the national workshop) were received. In an (less than ideal) attempt to gather additional data on the applicability of the results to other contexts, the BARS questionnaire was issued again more widely giving the 73 replies analysed (albeit cautiously) in Chapter 6. Although every effort was made to approach all those directly interested in alcohol-related harms and commissioning interventions, etc. (as a census sweep), the small number of replies do not constitute a representative sample. Of the responses received approximately one-third of these were from the NE of England. The results and analysis presented should be viewed with caution.

8.2.4 Researching in a changing context – meeting the study’s objectives

In this section we revisit the study’s original objectives in order to consider if these were met (and to what extent), and the steps taken to ameliorate any ‘drift’. We make reference to where, in the report, these issues are explored in more depth and the impact on the study is discussed. We consider the objectives in turn and include what we learn from these efforts.

8.2.4.1 Objective 1: to engage research participants in the research process (co-creation of knowledge) (meets RQs 1, 2&3).

Chapter two outlined our plan for co-creation (section 2.8) and chapter three the plan for making this happen (sections 3.3.4, 3.4 and 3.4.1), whilst chapter 7 reflected on what actually happened in detail. The reality did not match the promise, nor the plan. Despite agreeing with our case sites the core conditions that were needed in order for us to be able to select
them as a case site and work with them in co-creation (pick the topic and set-up a small local group that would work with us (a joint interpretation group) to consider the emergent findings and comment upon them), promises were not met. Sometimes participants prioritised other activities and meetings were cancelled or poorly attended (or attended by deputies). This issue almost exclusively related to Rosetown, where the English context was one of major reform, displaced staff and disruption to ‘business as normal’ as transition was managed. There is no controlling this. In both sites, regardless of discussions and written material, the notion of co-creation remained somewhat unclear. It is likely that efforts to work in co-creation need to be re-iterated and negotiated at each stages of the research process. Later we offer recommendations for further research on co-creation.

8.2.4.2 Objective 2: to track the commissioning process (and joint planning) in public health for research utilisation (meets RQ 1&3).

In Thistletown we were able to engage all stakeholders in the licensing process and to follow the live action as planned. In Rosetown, the process we were following stalled (as the market research company were unable to recruit participants to the local data collection that they were commissioned to undertake). In addition, in Rosetown, we were unable to engage the major providers of services fully in the research process (non-attendance at joint interpretation meetings).

In both sites there were places we did not get to see (the licensing board in Thistletown and the informal contacts between commissioners and providers in Rosetown) meaning that the full process was not observed. Both these points appear to suggest that we failed to meet our objectives, and this is one way of understanding what happened, however an alternative is possible – that these are simply findings. The first identifies a deeper concern between Rosetown commissioners and providers and the second that there are hidden places in commissioning and joint planning processes. These points are examined more closely later in this chapter and their implications explored. At the very least, it is fair to say that we did not get to see the full commissioning process in Rosetown and so care must be taken in considering our findings and later we recommend further research in this area (section 8.4).
8.2.4.3 Objective 3: to identify research management roles (and the opportunities and challenges posed by this role) (meets RQ 1&3).

We interviewed 32 ‘research managers’ across the two sites, six observations, and conducted two focus groups (n = 5 and n = 6) and chapter three identifies the various roles they held (data analysts, library services, intelligence managers, etc). The findings from these interviews are incorporated into chapters four and five (Thistletown and Rosetown findings). The overall conclusion is that these roles do exist, they represent the organisations efforts to identify, collate and mobilise evidence into planning and commissioning processes, but that the role incumbents felt that their skills and capacity (and opportunities to enter evidence) were largely underused. Later we offer recommendations on how to use the skills of research managers more fully (section 8.4)

8.2.4.4 Objective 4: to explore individual and organisational learning around research utilisation (embedding and sustaining research utilisation) (meets RQ 1, 2&3)

We were able to investigate this. In both organisations, the first formal organisational efforts to pull in evidence occurred at the time when strategic documents were refreshed, to identify organisational priorities and to provide an evidence-informed backdrop to subsequent activity. The second organisational response to ensuring evidence use was the provision of the ‘knowledge manager’ roles (as above). However, the use of the knowledge manager’s skills and the decision to pull in evidence beyond that included in strategic documents, came down to individual commissioner’s or planner’s, time, interest, and knowledge. Later in this chapter we offer recommendations for practice and future research in this area.

8.2.4.5 Objective 5: to explore any link between research utilisation and organisational performance (the impact) (meets RQ 1&3).

We were not able to meet this objective as discussed more fully in section 8.2.1 (also see above). Quantitative data is included in the case study findings chapters (4 & 5) to help the reader understand the public health issue in the case study sites, the extent of the problem, trends over time and how the site compares to other parts of the UK (without identifying the site). We identify some very real gaps in routine data and later we offer recommendations in this area (section 8.2.1).
8.2.4.6 Objective 6: to explore and discuss transferability of the findings (meets RQ 1, 2&3).

Here, again, our efforts again were only partly successful. We were able to feedback and validate emerging findings with our case participants. We were also able to share these findings and explore their applicability more widely in the case studies in two local workshops (n = 23 and n = 15). However, the response rate to the Delphi questionnaire and attendance at the national workshop (as detailed above) was poor, giving us only a limited understanding of how these issues may play out elsewhere. We have discussed these issues above.

It may be obvious to state, (but we will), that in turbulent times, when organisations, processes, roles and personnel are changing that planning and conducting empirical research is challenging. The research team has little control over the activity and can only attempt to work with it and around it. Perhaps, in some ways, this research gives examples of the level of disruption experienced by practice colleagues, (at least in Rosetown), during this period (and is a testament to them). The next section will consider the contribution of this study.

8.3 The contribution of the study

8.3.1 Re-affirming earlier findings

This study provides two detailed empirical accounts of evidence use in the processes of public health commissioning and planning which has been advocated as a gap in the evidence base (61, 92). In doing this it replicates findings from earlier studies that have looked at research utilisation and knowledge mobilisation. It re-iterates that the process is heavily dependent on several factors. The nature of the evidence itself: is patchy; often seen as dull; difficult to understand; not timely and historical; not a good fit in local contexts and not always fit for purpose, therefore contested. That uptake of evidence is more likely if: it is presented by a trusted and credible source in an active format; and if it is relevant to the context and tasks at hand; if key messages are teased out; and if the significance of the evidence is negotiated across stakeholders in trusting and ongoing relationships. Also that research evidence: is only one form of evidence and information used in making public health decisions; competes with other local pressures and vested interests and that tacit knowledge is
always embedded in decision-making which is seen as an art form rather than science (91). Below we move onto the contribution of this study. It will become clear that there are more commonalities across the sites than there are differences.

8.3.2 Public health and the dominant programme theory

We start the realist analysis with two key observations:

1) Both sites were carrying out activity in line with the EU, and the HIC (high impact changes) laid down in national guidelines (see chapter 2) for reducing alcohol-related harms and therefore, at the highest level, both sites were carrying out evidence-informed commissioning and joint planning.

2) Both case study sites collected local evidence for themselves. In Rosetown this may be explained by the inconsistencies in national evidence relating to the effects of maternal alcohol consumption in pregnancy. However in Thistletown, local data and evidence was similarly collected despite a well-established and robust evidence-base. We conclude that the collection of local evidence serves a purpose beyond merely filling-in the gaps in the evidence-base.

We return to both these pivotal observations in what follows. In this chapter we identify and explore the predominant programme theory and the context-mechanism-outcome combinations at play in the use of research evidence and other types of evidence in the commissioning and joint planning to reduce alcohol related harms in the case study sites. We consider structure and individual agency as they facilitate the use of evidence and what follows takes into account the extent to which the findings resonate across different contexts as illustrated by the national seminar and the BARS questionnaire. To do this, the argument moves away from a simple description of CMO combinations, in order to cope with the complexity of the process. As, explained below what is identified as the best course of action, is not clear till who, where, with what resources, when, how, and for what purpose also align. The use of different types of knowledge and information iteratively moves, rising and falling from prominence and is not static in the way that a ‘frozen’ CMO combination might suggest. Instead we give a high-level read-across and present two mid-range theories to account for the findings. One of the unexpected debates our findings open is: ‘what is
Public Health? We begin by referring to the World Health Organisation (WHO) definition of Public Health to initially close off this complexity, but end the chapter with this issue re-opened.

The WHO defines public health as (216) as:

“Public health refers to all organized measures (whether public or private) to prevent disease, promote health, and prolong life among the population as a whole. Its activities aim to provide conditions in which people can be healthy and focus on entire populations, not on individual patients or diseases. Thus, public health is concerned with the total system and not only the eradication of a particular disease. The three main public health functions are:

- The assessment and monitoring of the health of communities and populations at risk to identify health problems and priorities.
- The formulation of public policies designed to solve identified local and national health problems and priorities.
- To assure that all populations have access to appropriate and cost-effective care, including health promotion and disease prevention services.”

In other words Public Health has a defined (if broad) remit and three identified activities through which this remit is to be met.

The programme theory that underpinned and shaped the activity at play in this project (research utilisation and knowledge mobilisation) can be simply expressed as: Research evidence will enable Public Health functions to be met more easily (i.e. the bullet points). We chose to focus on the dominant programme theory, (largely the one at work in Western societies that values and privilege scientific evidence). In a complex study this focus was helpful to hone the data collection (interviews and observations). Within our focus on commissioning and joint planning, our data addresses primarily the second two bullet points (the design of Public Health policies and the provision of appropriate Public Health services and interventions).
8.3.3 What works (for whom)

It is clear throughout the project that what counts as evidence (proof) or ‘valid knowledge’ (53) varies considerably across stakeholder groups. The internal validity of research evidence (52-53) i.e. the robust and rigorous process through which the evidence is established gives that evidence a privileged (factual and generalisable) status for academics (and practitioners steeped in evidence-based traditions). However, decision-makers often look to the external validity of different types of evidence. When other forms of data and information appear to tell them more about their world and reflect it more accurately (external validity) than research evidence, (regardless of the precision with which it is produced), is relegated in favour of more salient representations of their immediate world. Participants at each site often referred to things being ‘different here’ or ‘special’ meaning that the conditions under which the research evidence might hold true, did not in fact, apply, rendering its message less applicable.

‘What works’ is not only about the nature of the evidence, but its mobilisation. How evidence is introduced, by whom, and the trust, credibility and likeability of the messenger impact on the likely uptake of that evidence into the decision-making process. Participants regularly reported using local opinion leaders to introduce material that they themselves would not be able to champion. Messages had to be ‘short and snappy’, relate to the day job, and have clear local implications with the preferred model (for maximum impact) being face-to-face (verbal and visual) as opposed to written, because of the immediacy of the impact.

8.3.4 A mid-range theory - saliency and immediacy

Pawson and Tilley talk of the ‘mechanisms’ that, within a context, are the socio-cultural active ingredients that shape the outcomes that are observed. In both our sites the socio-cultural mechanisms that encouraged the use of evidence (of all kinds) were twofold. One mechanism was the perception of local fit and relevancy to the situation at hand – saliency. The other was the immediacy of the evidence. To use slang, taken together both mechanisms make the message in the evidence ‘up-close-and-real and about ‘here-and-now’. Below these ideas are developed further as the core mechanisms that mediate to encourage (or discourage) the use of evidence. Several factors inter-relate to influence how useful (and usable) any
information will be seen to be. We can explain this through a mid-range theory based on these two linked mechanisms: saliency and immediacy. Evidence that is created here-and-now, as opposed to there-and-then is considered more salient. Evidence that is presented face-to-face, perhaps visually, and with active interpretation to pull out the key messages has greater immediacy than evidence that is passively presented in written documents. The closer the evidence to the setting of its use (geographically and temporally - context), and the more actively that evidence is introduced (explained, visualised, debated - mechanism) the more likely it is that it will be used (outcome). Researchers cannot assume that the evidence 'speaks for itself”, nor that decision-makers will share their views that the evidence is generalisable and will work anywhere. Below we conceptualise this relationship The direction of the arrow (overlaid) indicates the increasing likeliness that evidence will be used.
Ironically, this suggests that what counts as useful evidence and valid knowledge is intrinsically tied to where it is used and by whom. The data moves us away from a simple linear view of research utilisation (i.e. it is more complex than first deciding, what to do, then
when, etc.). Clearly, building relationships is important too, but we consider that to fully understand the use of research evidence, a complex systems view is needed. We develop this argument below. Whilst we continue to make distinctions between, what, whom, and where, as a heuristic device in order to discuss the findings, we acknowledge that ultimately they may prove to be artificial as it may be more useful to look at the totality of the decision as it is made not the component parts.

8.3.5 Where – evidence entry points (EEPs)

To use research evidence it has first to be available to be used. Our findings suggest that there are provisions within organisational arrangements in both case studies sites to pull in, use and embed research evidence to inform high-level decision-making for both commissioning and joint planning. However these official evidence entry points (EEPs) are few. The most obvious evidence entry point is when research evidence is both pushed and pulled into each cycle at set times to renew strategic documents (e.g. JSNAs; policy, strategy and planning documents). Most commonly, the research evidence is used to detail the nature and scale of the problem, what it is, where it occurs, and possibly how it is changing over time. This embedded evidence is then used to set organisational priorities. In this important way all activity that flows from these priorities is evidence-informed. However, research evidence used through this evidence entry point is used rather like floodlights to illuminate a football pitch showing where to play and take action, but not directly shaping any game that is played there, or how it is to be played.

There are implications in relying upon these high level EEPs alone. This embedded evidence may raise understanding and awareness of the problem, but not necessarily provide guidance on what to do about it i.e. local actionable messages. The nature of these documents is that they list the priorities in overarching, generic terms e.g. ‘alcohol’. The precise shape, direction and extent of any activities taken to address these high level priorities are decisions that are taken downstream in the organisation (i.e. what should be done to meet the priorities). At this ‘lower’ level, when actual commissioning or planning decisions are taken, the use of evidence is largely a person-dependent system with evidence mainly being
mobilised through the efforts of individuals, not structures or processes and is therefore necessarily patchy and variable.

Some of the formal evidence entry points that did exist, were not always used (e.g. the licensing forum pushing evidence to and requesting information from the licensing Board in Thistletown). From this example the findings suggest that a combination of formal structures is needed (the points where evidence enters) backed-up by a requirements to use them, and a cultural acceptance that this is the ‘done thing’.

Organisational responses to facilitating evidence use (research and public health data and intelligence establish various roles (knowledge management, knowledge officers, information scientists, data analysts, etc.), whose remit is variously to identify, gather, collate and push research evidence into the cycles. However, these potential evidence entry points are not necessarily used. Whether the data analysts’ skills (or information scientist, etc.) are drawn upon depends on the individual commissioner’s capacity to know that there may be evidence, how to access it, know what it means when they find it, interpret how to apply it locally and have the time to take these actions in collaboration with stakeholders. At these crucial times there are no formal organisational or structural requirements to bring research evidence to the table. In this way the evidence entry points we observed were used to formally pull-in research evidence to identify need, but far less-so later on as activities to address that need were decided upon. Flow of evidence (sometimes cascade of evidence) was not well developed and not seen as an expectation of the process, but left to the discretion, capacity and capability of commissioners / planners

8.3.6 What works - asking different questions of the data

One way to understand why it is not seen as crucial to identify the evidence base at the point where decisions on services and interventions are made is that there are few actionable messages to be found there (i.e. it is of little use given the task at hand – “not fit for purpose”) (53). When researchers ask; ‘what works’ and practitioners ask; ‘what will work’ deceptively they appear to be asking the same question of the data. This is not the case. The same words are used but it is a different question that is being asked. Anecdotally, when listening to
accounts of the effectiveness of Public Health interventions emerging from research evidence, practice colleagues often say ‘Oh that would never work here…’ If taken at face value this seems to run counter to the understanding of research evidence and the research process. Efficacy means that significant health improvements have been measured following an intervention introduced under controlled conditions (across a comparator) to establish proof of concept – that the intervention can improve health outcomes. However, that is not to say that in any one specific context it will. Scientifically, it is perhaps more accurate to claim that under the conditions under which the effect was observed the outcomes (health gains) followed, but not that those conditions (context, backdrop, and fidelity of the interventions) can and will be replicable elsewhere. Field trials are not always available – and even then ‘fields’ differ. It seems to be this difference to which practice colleagues refer.

The case study sites reported: “It’s different here…”, “We are special…” “…the problems are different…” when asked about the ‘fit’ of national evidence to the local context meaning that the prevailing backdrop (context) may make it impossible to reproduce the intervention, as it was designed, in order to replicate the health gains. When practice colleagues say ‘that would never work here’ – they are not challenging the efficacy (that under the prescribed conditions it will work) – but that they could not get it to work – that it would not be implementable locally in that way. The precise conditions under which health gains will follow cannot be replicated. ‘What works’ – although the same words mean different things to Public Health researchers and practitioners.

To understand this dilemma - we may understand the practitioners’ focus as ‘what might work here and now – what can I get to work – how do I do that?’ It is typically, not that the practitioner is necessarily unaware of the research evidence findings, but more that following them is not a recipe. To use an analogy, in practice they may blend ingredients from multiple Public Health recipes according to cooking techniques (tacit and professional knowledge) developed over years, to find a blend that will work in their kitchen to meet their customer’s needs – a kind of local ‘Public Health plat-du-jour’. This departure from the pure science of public health is not necessarily pathological, but fiercely pragmatic. In order to secure what interventions are possible (those that are feasible, acceptable) our practitioners (in the workshops) say, it is better to perhaps, sub-optimally, “Chip away” and change things over the longer term rather than fail with un-implementable approaches. Again, taking a complex
system view helps us to explain this (217). Having evidence that is “...good enough”, that moves things generally in "the right direction" that is achievable for now, even if not perfect or lasting forever, is the best way to deal with wicked issues [77-79].

8.3.7 The inter-linked nature of public health issues

Again, we see that what works, for whom, where and under what conditions are parts of the same question, they are not separate, distinct factors. Instead of considering these as sequential considerations when making a decision for commissioning or planning (first decide what, then where, then how, etc.) we suggest that the answer to one part of the question depends on the answer to the others. Public health issues are not single-stranded and solutions cannot be discreet or compartmentalised. No one part of the question is answered till they all are. The solution is not suddenly apparent, but emerges over time and in discussion as a resultant whole. This slowed-down evolution of solutions, opens decisions to influence at different parts of the process by different groups, this allows any final solution to reflect many factors and concerns. The final decision is held in abeyance until the decision-in-progress hits upon a solution-in-practice – typical of wicked problems and complex systems where solutions are only ever, partial, and temporary.

8.3.8 Under what conditions – context

We move on to consider what these situational factors are that shape ‘what works in situ’. The fieldwork suggests that multiple types of evidence e.g. (research findings, local statistics and local opinions, performance and health data) and information from what has been tried before and how that went (organisational memory) may be drawn in to inform commissioning and planning decisions and weighed against other considerations. These other concerns are largely contextual factors that need to line-up to allow any approach to proceed. There needs to be a consideration of ‘local fit’ (i.e. saliency) with regards to the acceptability and feasibility of the approach; how things can be accomplished (with what partners, through what champions and stakeholders and across what managerial mechanism –
(commissioning or joint planning)). Then all of this is considered against a backdrop of wider forces (political influences, macro-economic concerns and performance measures). Figure 11 illustrates some of this mix below, as identified in our fieldwork.

**Figure 11: To show the dilemmas of using Public Health evidence in situ**

This is a simple and simplistic representation and almost certainly not exhaustive. We use it here to reinforce:

- that research evidence is only one ‘part of the jigsaw’ (70) and;
- that at the centre of the process is a human-being subject to human strengths and foibles (peer-pressure; forgetfulness; stress, resilience and capacity to build alliances) so therefore commissioning and joint planning are ultimately social activities and;
- if these are the questions and dilemmas that commissioners and joint planners face, they are unlikely to all be answered by traditional Public Health research methods:
• that ‘outcomes’ of commissioning decisions do not follow research findings in any straightforward way.

8.3.9 The curious cases of the collection of local data

Figure 10 and 11 also helps us to understand why, regardless of whether there is plentiful national data and a well-established evidence-base (low saliency and low immediacy); both sites conduct their own local research (high saliency and high immediacy), to provide evidence that they both trust and can use (CMO combination that encourages evidence use)

A further explanation is that local commissioners and planners are trying to answer the questions that national evidence does not (and perhaps cannot) – what actions to take and how to achieve that change in their setting. However, other factors also seem to be at play. In Rosetown, lack of consistency in national guidelines regarding what public health messages to give to local woman regarding drinking in pregnancy made the identification of what interventions to commission difficult. Logically, this prompted the commissioning of insight work (the process case study we followed) to determine local acceptability and feasibility of any approach that would be proposed. This gives a direct ‘test’ (here and now) of the future likely success of any intervention and allows the public to help shape that approach. However, there is a hidden conundrum, the national evidence base already contains messages about what is typically acceptable to women and to midwives in delivering these messages (from various public health topics, smoking in pregnancy, drugs screening, weight management, etc), and from our data it is clear that the commissioners knew (or at least largely anticipated) what the local research would find – so why was there a need to collect this primary data? Overtly, it would appear that efforts are simply being duplicated. Form our data the reasons for this appear to be two-fold: a need to localise national findings in order to be convincing that the approach still holds merit locally (high saliency and high immediacy); and the need to be seen to do something. Both these are explored more fully below.

It is important to commissioners to be seen to do something, not only to address local need but to address multiple concerns (getting work initiated across new partners, securing early-wins across the new public health system, building new relationships, and spending allocated monies). Accountability within the role of commissioners and planners are not all about the
achievement of key result areas but in managing informal (and largely covert) relationships and expectations too. This brings face validity to their activities, ie they appear to be doing what they should be doing, and helps maintain credibility across stakeholders.

The need to localise evidence is very strong, high saliency and high immediacy seem to be core ingredients in mobilising evidence into action. A simple way of understanding the high saliency and high immediacy quadrant is that evidence here is ‘up close and real’. Below we continue analysing the implications of this, beginning with a look at the role of local evidence. It is the findings of this local research and data gathering that is more influential in shaping Public Health commissioning and joint planning decisions (i.e. helping Public Health practitioners achieve their aims – improved local outcomes), in both case study sites.

It is in the artful craft of seasoned commissioners and planners in Public Health and the partner groups with which they work that the balance between these competing forces is resolved in order for action to be taken and the system achieves stability by consensual adjustment of competing perspectives (217)

Tacit knowledge and professional identity informs their behaviour in relation to not only what to do, but how best to proceed with that and the wider factors that may still impinge on any decision. In Thistletown, local crime data, footfall and safety statistics that identify problematic areas, suggest what factors to take into account when deciding on granting licenses. Relationships with colleagues and the wider council agenda also informed choices (ie economic vibrancy and local reputation). We suggest that it is not possible to completely predict, in advance, which one of the factors in Figure 10 will be the most influential in any one setting. It is possible to imagine polar extremes, for example where a ground-breaking piece of science changes routine practice forever, overnight. It is equally possible to imagine situations where local political pressures dominate what action is taken and equally it is possible to think that local people can make-or-break plans. It is to these three groups: science; politics and the public that we offer a conceptual way of thinking about these competing tensions and a mid-range theory. (See Figure 11).
8.3.10 A mid-range theory - blended solutions and a visual schema

Above we discussed that commissioning and planning decision are held in abeyance under consideration subjecting them to multiple contextual factors. In Figure 11 below we conceptualise this process as a tension across three main forces: politics / influence (power), science, evidence (truth), and public and acceptability (legitimacy).

![Visual Schema]

Figure 12: To show a visual schema to illustrate competing forces and blended solutions in Public Health decision-making

To explain the figure we begin by using polar extremes. A fully red decision (ideological dictatorship) would be imposed with force against the will of the people and without scientific basis. A fully blue decision (scientific rationality) would reflect only logic without humanity or consideration of competing world views. A fully yellow view might be anarchy without political structure or scientific order and discipline, where people were left to please themselves. What we see in practice is the pull of the competing forces, some weaker some stronger. Any resultant commissioning or planning decisions may reflect the influence of the three forces differently giving it, literally, a different hue.
In Thistletown licensing decisions taken in line with local culture (yellow) and with strong local political and trade influence (red) contains ‘less blue’ (weaker reflection of the evidence-base), giving a more ‘orange’ decision. In Rosetown, some ‘blue’ exists as midwives collect data in answer to the ante-natal booking questions on alcohol consumption and practice in accordance with the evidence as it is embedded in guidance from the RCM. However in the absence of unified messages from research evidence this message is dissipated. In absence of the ‘blue’ here the midwives may draw upon personal values and personal experience to give legitimacy to their choices (yellow).

Across different settings and even within the same setting (at different times) the strength of each force will differ (by issue, risk, according to the personalities of those involved, the history, etc.). The schema gives a way of understanding local variation and permits reflection upon the somewhat unpredictable ebb and flow of contextual factors in shaping local public health decisions and the nature of interventions (outcomes). The use of evidence in public health decision-making (in both contexts) is fiercely pragmatic, requiring the balancing of scientific evidence with professional judgement in light of prevailing local conditions. Our findings suggest that this is vital in achieving the sound application of evidence of all types. 8.3.1.1 Democratic Legitimacy

In our case study sites (particularly in Thistletown), the participants referred to the need for any decision taken to have democratic legitimacy. By this they did not mean that the public health decisions taken were subject to a vote, nor consultation, nor that the decisions had to be taken by democratically elected members. To understand what they did mean, it is worth returning to the schema and looking at the yellow force – the ‘people’. In neither of our case studies did ‘the people’ directly get to input to the commissioning or joint planning decisions taken – they simply did not have a direct voice. The schema reflects this and the ‘pure’ yellow line is thin. The public can directly shape decisions via pressure groups, social movements and protests for example; however most often there is no public ‘voice’ asserting direct influence. Yet, the blue and red shapes surrounding the yellow have their colours changed by the yellow influence. Public Health decision-makers and elected members alike, can and often do, shape their decisions on what they think will be acceptable to the public, feasible in their settings, and make the lives of local people better. The public presence is definitely there. In our data there was a strong backdrop (almost a moral dimension to the
decision-making – trying to achieve the greatest possible good - utilitarianism). The power-base behind the elected members (in Thistletown) arises directly from their position in being elected to ‘speak for’ the people. The power of the foundation trusts in Rosetown arises directly from their capacity to deliver services (or not) to so many people. The people’s voice (the democratic legitimacy) is negotiated amongst the players active in the commissioning process (commissioners, planners, elected members, etc.) and most often not directly by members of the public, but the assumed public voice is strong. To twist Derrida’s notion they are almost like a ‘present absence’ (218). Exactly who is seen to speak most faithfully on behalf of the people (what they want, what is important them, or good for them) was often at the heart of the differences in views across the stakeholder groups.

8.3.12 The ontological status of the schema

Realist approaches permit the building of mid-range theories. We suggest that the schema above is a mid-range theory presented visually (219) however there are a number of caveats and limitations to the schema that need to be outlined. Firstly, here, in using the schema to help understand the use of Public Health evidence in commissioning and joint planning we envisage two other competing forces: political forces and public concerns and aspirations. There could be others, for example economic forces, risk/safety, legal forces. In the case study sites where economic considerations were part of the action they clearly fell into the political domain (for example in Thistletown as the influence of the ‘night-time economy’). It is possible that if the figure is extended as a heuristic device to explain other situations where competing forces act concurrently to shape planning and practice activity, then the forces identified may change to give different pulls across the schema.

Secondly, colours are allocated to the competing forces to illustrate the resultant blend between the forces. However, even the colours themselves cannot be taken as constants given the complexity of the world and its ever-changing nature, what constitutes bright blue today might be different tomorrow (as the evidence-base changes). Similarly what constitutes bright red (power/influence) might also change as elections see the rise and demise of different influential groups, so the colours themselves may mean different things over time. In other words although the colours show the blend of factors, we do not know
what they represent in the real world. The public health interventions put in place today as the result of a light purple blend may be very different from what that same blend would have looked like 50 years ago or 50 years in the future. The schema and the ideas it illustrates are abstractions - perhaps best used to: prompt thinking about how the forces inter-relate; consider the implications of this and; devise possibly more useful blends, rather than suggesting what direct activity any particular colour represents.

Thirdly, it is necessary to demonstrate the capacity of the schema to illustrate our case study findings. In Thistletown, the full range of dilemmas involved in the consideration of licensing applications can be illustrated in the following example (we have modified the example to preserve anonymity).

There is a (fictitious) piece of local wasteland in an alcohol-dense (over-provided) area that a large supermarket chain wishes to develop. Their planning application includes an application to sell alcohol. Perhaps strict adherence to the local alcohol policy statement might reject the application in an over-provided area (blue). However there is a rebuttable presumption to grant the license (red) and legally it is not easy to demonstrate the contribution of this license to health related harms as the premises have not yet sold any alcohol (red). In addition the supermarket will bring jobs (yellow, red, blue) and sell fresh fruit and vegetables (yellow and blue), bring re-development to a crime ridden area, and pay for some up-grading to the roads and footpaths (yellow, blue and red).

It is difficult to be a purist adhering only to the research evidence as it is embedded in the alcohol policy statement (alcohol-related harms correlate to alcohol availability and outlet density), because as the figure shows a solution will / needs to meet multiple competing forces. Even if the solution disregards the alcohol research evidence, grants the licence and the supermarket is built, it may lead to health gains in other areas. Overall greater health gains may result from granting the license. Ironically a blend with less ‘blue’ may give greater health gains, suggesting that not all health gains (nor the inter-related complexity between them) are captured by a siloed evidence-base.

The schema shows us the inherent complexity in public health issues - what is in the interest of the public’s health? This issue is typically closed down by the controlled designs used to create (single issue, often siloed) public health evidence, but re-emerges during the
commissioning and joint planning processes. In this way, the figure allows us to see that debate, blending of evidence types and sources, is not pathological but can result in commissioning and planning decisions that, whilst they seem to work against the strict research evidence base, actually may result in unrelated wider health gains. This involves taking a wide view of public health. In our democratic society the adversarial role of competing groups maintains checks on the excesses of a single approach and the same may be the case here.

In Rosetown similar competing forces were observed. Midwives’ reluctance to ask the pregnant women in their care questions about their alcohol consumption could be interpreted as ‘resistance’ and a wilful disregard of the evidence base. However, this only holds true if one considers that the research evidence (e.g. on FASD) is the only possible health outcome. Our data suggests that practitioners may in fact believe that they are acting for the greater good (and for the wider health) of the women and their unborn child in not jeopardising the relationship and continuity of care. This also raises questions about who is the focus of public health interventions, mother or baby, when there are tensions in the evidence about what works best for whom, at different times. Answering realist questions in public health issues is complex.

8.3.13 The managerial mechanism - commissioning versus joint planning of Public Health interventions

So far we have discussed the similarities in the use of research and other types of evidence in both our case study sites. Our findings suggest that the similarities far outweigh the differences; however, there are some differences. We have argued two things:

- firstly that there are few EEPs and that formally research evidence tends to enter primarily at strategic level and only at set times in the process (when reviews are undertaken and priorities set). Later in the commissioning (or planning) cycle where these priorities are operationalised and interventions designed, the use of evidence and other types of information is largely person dependent.

- secondly, we have also argued that the effective use of evidence means taking account of competing pressures in the context to achieve the most feasible and acceptable
blend and work towards a wider appreciation of what is in the interest of the public’s health. In line with this, both case study participants emphasised the importance of discussion, co-ordination and collaboration across partners holding shared responsibility for intervention development and delivery.

It was unclear at the start of this project, whether it is easier to secure the use of research evidence via a legal contracting process (across purchaser-provider) or within unified organisational arrangements with shared responsibilities. It is now much clearer from the data that the different managerial mechanisms permitted this negotiated space to varying extents. Chapter 5 details the difficulties experienced in creating opportunities to discuss options over the purchaser-provider split. Under commissioning (and procurement) restrictions, participants talked about the difficulties of meeting to agree plans and actions and having to use informal (un-condoned) links across the purchaser–provider split to work towards feasible and acceptable solutions. In Thistletown, under joint organisational arrangements the first thing that happened in our work with them (somewhat delaying our entry) was a meeting across partner organisations to agree participation and decide on the topic (no equivalent meeting happened in Rosetown).

Commissioning attempts to give the commissioning organisation increased legal contractual power (red) to help them to lever their preferred choice across the competing forces, but in doing so this drastically reduces the legitimate opportunities for achieving the democratic legitimacy we outline above. Ironically, in not allowing the blend of the competing forces to be resolved through agreement (finding a ‘natural’ balance within a complex system), other parties may resort to red solutions too (e.g. the power exerted by Foundation Trusts and other providers in commissioning processes) to push-back to redress the balance.

8.4 Recommendations for practice and future research

Above we have used the saliency / immediacy mid-range theory to locate our findings and begin to explain the socio-cultural mechanisms at play in our contexts. A second mid-range theory, as a visual schema of the competing tensions at play when making complex decisions to address wicked problems in public health has been presented. Below we end by making some recommendations for further research.
We fully acknowledge that this has been a small study and care should be taken not to over-interpret the findings.

8.4.1 Recommendations for practice

8.4.1.1 Few evidence entry points

In both sites there were few official evidence entry points where there was a requirement to pull research evidence in to the decision-making process (and not all these were used). When research evidence is pulled in it is mainly to refresh strategic documents (e.g. joint strategic needs assessments and strategy documents), this identifies public health need, but not necessarily solutions. Beyond this, the research evidence base is rarely directly considered, unless driven by the particular interests of individual commissioners. With a burgeoning evidence base and increased efforts to share research evidence across sector boundaries (for example fuelled by the impact agenda within the research excellence framework), it is arguable that a duty lies with organisations to ensure that they manage their use of evidence more effectively.

Professional expertise, tacit knowledge, and local and organisational memory are extensively drawn upon to decide on commissioning and planning decisions and activities. Research evidence is pushed into the organisations from several providers (Universities directly, evidence synthesis organisations e.g. NICE, and other national bodies e.g. PHE).

Recommendation: If organisations take seriously their commitment to use the evidence base then more formal effort could be taken to mobilise the evidence that does exist. There may be many ways of achieving this (beyond simply circulating paper and electronic copies of guidance, etc) by: actively incorporating evidence on interventions (what works as well as what does not work) into documentation: creating a standing agenda item in commissioning meetings on the research evidence base; co-opting information scientists, analysts and possibly academics on to commissioning groups (and using their skills); identifying the evidence base in commissioning specifications; senior leaders setting an expectation that consulting the evidence base is culturally the ‘done thing’.
8.4.1.2 Gaps in Quantitative Data

This study has identified some real gaps in national and local data capture in the areas of alcohol licensing and maternal alcohol consumption (with data not recorded consistently, or not collated and located in one place, or based on self-reports, or not collected at all). Performance indicators (and other measures of quality) have changed as have the organisations that both collected them and on which they are based. Some data is only available within the NHS (see the start of this chapter). It is difficult for commissioners to make sound decisions, when they are unable to obtain feedback and assess how well current or previous services are working. It is also difficult for academic researchers to draw sound conclusions using valued quantitative metrics. Without sound data capture, which is both consistent and longitudinal it is difficult to establish if change is an improvement and is impacting positively on health outcomes.

Recommendation: the recent reforms are now operational and overarching bodies like PHE becoming established. It could be timely to review routine data capture and whether old systems still capture the right data in the right way for the new structures. We hope this research is helpful in suggesting some areas of focus.

8.4.2 Recommendations for research funders

8.4.2.1 Co-creation, timescales and urgent research need

It took more time than we expected to explain co-creation to our research participants, identify the topic and generally negotiate entry – longer than the four months built into the proposal. Arguably if the practitioners with whom we had worked on the bid had been our research participants, this delay might not have occurred as they would already have been familiar with the approach and research aims, and wanted to work with us in this way (rather than having to be ‘persuaded’ as our sites were). This suggests that co-creation will work more smoothly if the practitioners who write the bid are to be the research participants. However, as in all complex systems this ‘solution’ creates additional ‘problems’. Our aim was to work on a topic that was of urgent pressing need for our research participants and it is not at all clear if the length of time (from writing of the proposal through outline and full
stage of application, contracting and recruitment of researchers – all necessary and rigorous processes) would make this possible. It is likely that any issue identified as pressing would be different by the time funding was actually secured, (and even more distant once data was collected and results known). Our research participants already stated surprise and frustration at the time that fieldwork took to get underway (after seeking ethics and R&D approvals).

Recommendations: There is no one clear way forward here. Several possible parallel steps may ameliorate these issues. For pressing, urgent practice research needs, a rapid and responsive mode of national research application could be created. This would help to keep national research funders aligned with fast changing practice contexts and needs. A different approach would be to solely devote national funding to longer-term issues (future big issues). A third alternative is, that if national funding is sought for urgent participant-led topics (ie following the approach adopted in this study), that considerably more time is allowed for both negotiated entry and consultation during the write-up stages. This entry period would need to be funded in order to allow the research staff who are to work at the sites to work alongside and build trust with the research participants.

8.4.3 Recommendations for researchers and educators

8.4.3.1 Making evidence fit for purpose

Often the public health research, data and intelligence identified in this study was focused on the nature, prevalence and trends of the problem and much less on “what to do about it”. This public health research evidence base was often seen as dull, difficult to understand, out-of-date, largely irrelevant to prevailing local conditions and carrying no actionable messages. Both sites conducted their own local data gathering to create clear actionable messages. Often it was this small scale local ‘research’ that shaped commissioning and planning decisions. There is often plentiful narrative and qualitative evidence (the sheer scale of which, some argue, builds its own convincingness (REF)). The increasing attention being paid to the impact agenda with the Research Excellence Framework provides recognition to researchers who work in applied research areas and an impetus for researchers more
generally to get their research to ‘make a difference’. Research evidence does not ‘speak for itself’.

**Recommendations**: Whilst many academics already carry out applied and engaged research, there is still scope to develop these approaches further. Academics might consider widening what counts as ‘good evidence’ (not judged solely by its internal rigour) to its external validity and its capacity to be useful (and used) in practice. Draw upon wider sources of evidence beyond the confines of the hierarchy of evidence and (for example Cochrane reviews) to include the contextual pressures that mediate upon the effects of ‘what works’ in messy contexts. Evidence does not speak for itself – but needs key messages highlighted, and presenting in clear, active messages to a targeted audience in a way that helps them to their tasks (53). Consider using local respected practitioners to pass on key research messages to inform practice. Consider what can be learned from the small ‘research companies’ that carry out locally commissioned work for practitioners – why are their ‘research products’ more useful in situ than traditional research approaches. Can any of this learning be used to make robust research evidence more fit-for-purpose, usable and used in practice.

For educators, teaching the substantive health topics is of vital importance, but also it important to consider teaching students interpersonal skills in persuading and influencing others and how to have difficult conversations. This may equip them to handle the difficult (sometimes politically charged, sometimes embarrassing) conversations they will need to have in their jobs. This may help mobilise research evidence in both decision-making and in therapeutic settings, without alienating colleagues or clients.

*8.4.3.2 Working in co-creation*

Awareness-raising was needed to prepare research participants for working in co-creation. The time needed by all stakeholders to engage in co-creation was considerable, and difficult to achieve amidst completing pressure (especially in times of significant change). Stakeholders, if not all engaged from the beginning, risk seeing efforts to collaborate as imposing events on them (rather than working with them to find solutions). Not all practitioners (or stakeholder organisations) were willing or able to engage. We reflected in chapter 7 that because our case study participants were located some distance away from us,
that we remained ‘outsider’s and though we spent short periods of time on site (interviewing and observing formal meetings), this was probably insufficient to build the familiarity and trust needed for full co-creation. We missed the ad hoc conversations, chats in the corridor, and impromptu meetings, where some of the work and decision-making associated with planning and commissioning happened (ie in the informal spaces between formal meetings).

**Recommendations:** Build-in additional, funded research time to facilitate the approach. Be prepared to explain what is being done, when and why to raise awareness at all stages of the processes. Co-creation worked better where: participants were fully informed (and understood) what was involved, where all stakeholders were willing to engage from the start; and where competing tensions were accommodated (e.g. emergency meetings) and collaboration were managed side-by-side. Simply adopting the orientation of ‘trying to be helpful’, of being ‘guests’, and ‘not being the experts in the room’, were good starting places. In practical terms, personalities, historical tensions and ongoing churn will be present in any context. A non-judgemental pragmatic approach, non-partisan and with incremental adjustments to remain feasible allows the approach to be adapted to the setting, rather than sticking to a regimented plan. It is likely that co-creation might be more successful (build greater trust, reach more ‘hidden’ areas) if conducted on-site (through secondment and possibly within an ethnographic design).

8.4.5 **Recommendations for future research**

8.4.5.1 **Researching the new public health system’s use of evidence**

It is difficult to identify examples where research evidence is used directly. We only found one example where a piece of research evidence was directly used. Clearly *if evidence is used – the overt use of individual studies in not how this is done*. Most often an evidence-informed backdrop is assumed (informed by the strategic documents), but this is largely unspoken. More work is needed to understand what using research evidence actually entails if not direct, instrumental application. In addition, we did not get to observe the HWB in Rosetown, as they declined to take part in the research as they were still in the process of formation and grappling with their own key processes. Given that they are the main
receivers and synthesisers of research evidence, and responsible for its cascade and flow in their formation of the HWB strategy and the Joint Strategic Needs Assessment, (the main evidence entry point), and that these documents shape all the activity that follows, their role in the promotion of research mobilisation is paramount.

**Recommendations:** It would be useful to research this process further. The new public health system (and wider health and public sector landscape) is so new, that it is not clear how, why and what types of information are included (or excluded) from these documents and to what extent practical solutions for local action are (or can be identified) and who does this work. It is also unclear what the roles of other key stakeholders are in this process (e.g. Clinical Commissioning Groups, PHE, and NHS England). It is unlikely that evidence (of all types) is only flowing downwards from the HWB, but across and back-and-forwards between these bodies. What evidence entry points exist in each of them and how do these bodies manage these processes internal and across their boundaries to their partners. These processes have the potential to spread research evidence use more widely or alternative curtail and close off research evidence use locally (reducing variability in practice in a non-evidence informed direction). This merits further investigation.

8.5.4.2 Researching the elusive nature of commissioning

Commissioning and planning as activities were difficult to pin-down, (ie not a clear-cut thing, (one-off decision), happening in an easily identifiable place). In the research we interviewed key stakeholders and observed the places where we believed the core activity to be taking place, but we did not get to see all the places (ie licensing board meetings in Thistletown and informal meetings between commissioners and providers in Rosetown, or email correspondence in either site) where some of the decision-making / action undoubtedly took place. In our study (and our data which is solely based on one commissioning site), research utilisation was made more difficult to achieve across the purchaser-provider split because it reduced the opportunities for interaction on which evidence flows largely depends (17, 19, 21, 30, 50-52, 55, 70, 75,-76, 78, 82-87, 91-93). The non-engagement of all stakeholders removed the opportunity to “achieve stability by consensual adjustment of competing perspectives” (217). However, in practice there are different models of commissioning (219-220) and the same may not hold true for all of them. It may be that it is the engagement and
ownership (or lack of it) that are the key socio-cultural mechanisms for achieving the sharing of knowledge (and that this is in turn facilitated by saliency and immediacy as we have attempted to illustrate) that is driving this finding. Our conclusion here, is based on our data which suggests that within joint planning engagement is required, and within commissioning engagement is sometimes rejected in favour of the ‘Chinese wall’ that contracting (non-transparent and at a distance) offers. In summary: joint planning provides the context (C) whereby the mechanism (M) (of engagement and ownership) flourish and help shape the outcome (O) of shared knowledge (CMO combination).

Recommendations: It would be helpful to understand how evidence flows in the different models of commissioning. In addition research that shadowed commissioners and decision-makers to explore the activity that happens in the informal spaces (and the role these places serve in shaping evidence use) to illuminate the full process, would be helpful in understanding how to shape evidence for different purposes. Formal research accounts (data and statistics) may fit better with strategic documents, but personal accounts (patient and client stories) may be more impactful in the informal spaces.

8.5.4.3 Is co-creation worth it?

Our research participants did not fully engage in the research process. Partly this may be due to lack of capacity or capability, or the unsettled and changing context in which our fieldwork took place. Our research shows that where interpretation was shared new insight was gained and that our research participants believed that involvement in the research had moved their thinking forward. We were abler to point to not only such intangible outcomes of working in co-creation but also to some tangible changes too (e.g. the creation of a new post in Thistletown to supply public health evidence in to the gaps in the process that we identified). It would be useful to know more about the barriers and facilitators to active engagement and whether the time, effort and resource (meeting time) on the part of the research team and the research participants make this effort worthwhile (tangible and intangible results and possibly cost-benefit analysis).

Recommendations: Within the ever-growing emphasis on translational research, impact, ‘making a difference’ and ‘what works’ researchers are increasing working in new ways and in places (mid-way between academe and practice) than ever before, yet, the methodological
development for doing this well, lags behind. Barriers and facilitators to evidence use are increasingly well known, but what is less well known is how a research evidence base and research efforts can address these. A stream of funding dedicated to the in-between world of knowledge brokerage (20) would move theory and research practice beyond viewing translational research as merely dissemination activities.

8.5.4.4 Competing tensions in shaping public health interventions

There would be merit in exploring how the competing tensions schema (above) holds-up to further testing. As a visual schema, it would have immediacy and if the competing forces relate to the setting in question, it would also have saliency. It could prove to be a powerful tool in allowing different stakeholders to examine their decision-making and de-personalise sensitive issues that are hard to raise in order to identify the forces that shape the final outcomes. This would enable those making the decisions to ‘stand-back’ and view their decision-making process more objectively, consider all the issues and pressures openly and allow them to assess how, what, and if they should privilege different forces. This could empower all stakeholders in the decision-making process. It would also be useful to explore the mid-range theory that identifies immediacy and saliency as core mechanisms in facilitating evidence use and the implications this may have for the way research findings are created and offered for uptake.
Acknowledgements:

We acknowledge the support of the NIHR HS&DR programme in funding this project. We also acknowledge the input of Dr Rosie Ilett, formerly of the Glasgow Centre for Population Health, who commented on and helped draft the original research proposal, and Professor Luke Vale, Health Foundation Chair in Health Economics, Newcastle University, who provided additional economic input. This report is dedicated to our research participants who took part in this project and who worked with us in co-creation.

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Disclaimers:

Department of Health Disclaimer: The views and opinions expressed therein are those of the authors and do not necessarily reflect those of the HS&DR Programme, NIHR, NHS or the Department of Health.

Contributions of authors:

Professor Rosemary Rushmer (Professor in Knowledge Exchange in Public Health: Knowledge Exchange) was the Principal Investigator on the project, providing oversight and writing the final report.

Dr Mandy Cheetham (Research Associate: Knowledge Exchange) was responsible for the fieldwork, analysis and write up of the English Case Study Site and contributed to the cross case discussions.

Lynda Cox (Improvement Development Lead) provided advice to the research team during the project as co-applicant and commented on interim findings.

Professor Ann Crosland (Professor of Nursing: Public Health) provided advice to the research team during the project as co-applicant and commented on interim findings.
Dr Jo Gray (Senior Lecturer Health Economics: Health Economics) conducted the health economics analysis.

Liam Hughes (retired; former National Adviser for Healthy Communities: Healthy Communities) provided advice to the research team during the project as co-applicant and commented on interim findings.

Professor David Hunter (Professor of Health Policy and Management: Public Health) provided advice to the research team during the project as co-applicant and commented on the interim findings and the final report.

Karen McCabe (Research Associate, Knowledge Exchange) was responsible for the fieldwork, analysis and write up of the Scottish Case Study Site and contributed to the cross case discussions.

Dr Peter Seaman (Public Health Programme Manager: Qualitative Specialist) provided advice to the research team during the project as co-applicant and commented on the interim report and provided input on the Scottish policy context for the final report.

Professor Carole Tannahill (Director of Glasgow Centre for Population Health: Health Policy and Strategy Developments) provided advice to the research team during the project as co-applicant and at the inception of the project.

Dr Peter van der Graaf (Research Fellow: Knowledge Exchange) was responsible for the knowledge manager interviews on each case study site, their analysis and write-up and contributed to the cross-case discussions. He also analysed the Delphi questionnaire.

Publication(s)

None to date.
References


3. House of Commons Science and Technology Committee Evidence-based policy in development network.


25. EB Nursing Practice. Available from: http://www.ebnp.co.uk/The%20Hierarchy%20of%20Evidence.htm


31. Øvretveit, J. What are the advantages and limitations of different quality and safety tools for health care? Copenhagen, WHO Regional Office for Europe (Health Evidence Network


97. Academy of Medical Sciences. Calling Time: the nation’s drinking as a major health issue 2004 [cited 2012 02/07/2012]; Available from: www.acmedsci.ac.uk.


144. Robinson, J., Laverty, L, Holdsworth, C, , Talking About Alcohol. 2011, Liverpool Primary Care Trust and Liverpool Health Inequalities Research Institute, Liverpool University.


198. Glasgow Centre for Population Health, *Policy Background to Community Health Partnerships and Community Health and Care Partnerships 2007*.


Appendices
Appendix 1. Interview Topic Guide for NIHR HS&DR Research – those involved in commissioning or joint planning process case study

1. Welcome & Introduction

Introduce self & thank participant for taking part

- Outline study

- Inform participant of the approximate duration of the interview and how the process will be conducted

- Ensure participant understands what is involved, has given informed consent and is able to withdraw this at any point during the interview

- Ensure participant understands extent of confidentiality

- Ensure participant is comfortable with venue / layout / temperature etc

- Introduce self/thank for participation/run through confidentiality and ability to opt out at any moment

2. Background/Context/Setting the Scene

- How does the commissioning / alcohol licensing process work here?

- Can you explain your role in relation to the commissioning of services / alcohol licensing?

- What helps you make decisions about what to commission/ alcohol licensing?
  - What influences you?

OR

- What informs commissioning / alcohol licensing decisions?
  - What influences the decision makers

3. What is evidence and how is it introduced?  (Prompt - Information can refer to research evidence, figures and trends, professional know-how, collective memory and experience of how things have worked in the past).

- When I say ‘evidence’ what comes to mind?
• How are different types of information used in the commissioning/ decision making process? How do you choose what information to use?

• What kind(s) of evidence do you think is used to inform decision making here?
  o Where does this evidence come from? Source(s) of evidence?
  o Who uses it / In what ways?
  o Where? When? How?
  o Where does it emerge from? Who brings it in / introduces it / tables it?
  o Why this particular form of evidence, in this situation/context, at this time?

4. How does this process work/ What happens to information/ evidence?

• What factors help / hinder the use of evidence in this process?
  o Barriers / Opportunities?
  o Is this the same in relation to other commissioning decisions?

• What is seen / treated as important evidence?
  o Why is this so?
  o Is one person/organisation’s evidence more credible? Why is this so?

• What are the individual / organisational factors that support or hinder the use of evidence?
  o Why? / How? / How does evidence spread?

• How is evidence used?
  o How? / by whom?/ to what effect?
  o ‘Do you think different people make different uses of the evidence? / prefer different types of evidence?’

• Do people challenge the evidence that is presented? Why / not? How?

• Have things always been like this? Are things changing? If so how and why?
  o This might be explored in various places
5. Who decides which evidence should be used and when
   - What, if any influence do you have over how evidence is used?
     (personal/professional/organisational) If not you, who does have influence?
       - What kind of influence? / With whom? / To what effect? / What was the impact of this?

   - Can you give examples of how, evidence is / has been used to guide decision making?
     - What was this evidence? / By whom?
     - Why this particular form of evidence, in this situation/context, at this time?
     - To what effect? / what was the impact of this
     - What factors made a difference? (professional status, experience, skills, expertise, competence, power, influence, credibility, timing, environment, partnerships, protocols, organisational context, resources, relevance?)

   - Can you give me an example of when evidence was used well (to good effect) and / or when you think the outcome was less effective?

6. Own experience – if any
   - Have you ever presented/introduced evidence? If no, why not? If yes;
     - What was this / how did you source it/ why did you think it was useful
     - How did you introduce it – at what forums/ meetings etc / via email?
     - What was the reaction to this / how did you feel
     - What was the impact of this?
     - Did this evidence inform people’s knowledge, ideas, attitudes? If yes, who and how? Did it inform commissioning / planning decisions? How?

   - Does research evidence always hold the best solutions / recommendations? Is it most useful? Why / why not / examples?

7. What else influences decisions?
   - What other evidence is there?
o How is this also used? How is this different to what is used? What value does it have? / to whom?

- Is this other evidence valued in the same or different ways to what we have already discussed? How? / to whom?

- Are there sometimes reasons not to act on the evidence? If yes, why? Examples?

- Do the views of the service users / patients / carers / public feed in to commissioning / decision making? How?

- What else should we consider, alongside evidence as important factors which make a difference, not covered so far?

- Which other stakeholders have important roles to play in whether and how evidence is used here? Who? Why?

- How do you think you are viewed, in terms of using evidence in commissioning / alcohol licensing, in comparison to other cities/areas?

8. Is there anything you would like to add that has not been covered in the interview?

9. Is there anyone else you think we should interview in this study?
   - What is their role?
   - Why do you think it would be important for us to speak to them / what would they bring to this study?

10. Recap & Closure
    - Thank participant for taking part and for the information they have given
    - Ask the participant if they are happy for the interview data to be used within the study
    - Inform the participant that if they would like to see the summary of interview findings/final report how this will be disseminated/made available
    - Give the participant contact details for the study team and contact details for the project lead
    - Leave duplicate copy of consent form and PIS
Appendix 2. The interview consent form

Name of researcher taking consent: ...............................................................................

Name of participant: ...........................................................................................................

- Please put your initials in the column provided beside each statement to show that you agree with the statement and give consent

- Please sign and date this form overleaf to show you give consent to all initialled statements

<table>
<thead>
<tr>
<th>Statement</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>I confirm that I have read and understand the information sheet (version 1) for the above study. I have had the opportunity to consider the information and to ask questions and I have had these answered satisfactorily.</td>
<td></td>
</tr>
<tr>
<td>I understand that my taking part is voluntary, and that I can stop participating at any time, without giving a reason.</td>
<td></td>
</tr>
<tr>
<td>I have been told that the interviews will be audio recorded, and that the tapes will be transcribed, analysed and then deleted. Transcriptions will be securely stored at Teesside University for ten years after the end of the project, then destroyed.</td>
<td></td>
</tr>
<tr>
<td>I understand that any information collected will be stored under secure conditions within the University and that only members of the research team will see my data. I give permission for these people to see this research data.</td>
<td></td>
</tr>
<tr>
<td>I understand that audio recordings will be sent to an external transcription services located elsewhere in the UK (there is a confidentiality arrangement between this provider and the University).</td>
<td></td>
</tr>
<tr>
<td>I am aware that direct quotations may be used in reports, academic publications and conference presentations, but understand that participants being quoted will not be identified.</td>
<td></td>
</tr>
<tr>
<td>I consent to take part in this research project.</td>
<td></td>
</tr>
<tr>
<td>I would like to receive a summary copy of the research results</td>
<td></td>
</tr>
<tr>
<td>I understand that I will be given a copy of this signed consent form.</td>
<td></td>
</tr>
</tbody>
</table>
I consent to take part:

Participant Name:

Signature:

Date:

-----------------------------------------------------------------------------------

TO BE COMPLETED BY RESEARCHER on attendance at the interview:

I can confirm that I have explained to the above-named participant the nature of this study, and I have given adequate time for any questions to be asked and answered regarding the study.

Signed ................................................................. Date

....................... 

Name (in capitals) ..............................................................

Post

..................................................................................................
Appendix 3. The observation consent form

Name of researcher taking consent: .................................................................

Name of participant: ............................................................................................................

- Please put your initials in the column provided beside each statement to show that you agree with the statement and give consent

- Please sign and date this form overleaf to show you give consent to all initialled statements

<table>
<thead>
<tr>
<th>Statement</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>I confirm that I have read and understand the information sheet (version 1) for the above study. I have had the opportunity to consider the information and to ask questions and I have had these answered satisfactorily.</td>
<td></td>
</tr>
<tr>
<td>I understand that my taking part is voluntary, and that I can stop participating at any time, without giving a reason.</td>
<td></td>
</tr>
<tr>
<td>I have been told that notes will be taken during the observations of meetings about the use of evidence indecision-making and that these will be written up, analysed and securely stored at Teesside University for ten years after the end of the project, then destroyed.</td>
<td></td>
</tr>
<tr>
<td>I understand that any information collected will be stored under secure conditions within the University and that only members of the research team will see my data. I give permission for these people to see this research data.</td>
<td></td>
</tr>
<tr>
<td>I am aware that no direct quotations from the observation of meetings will be used in reports, academic publications and conference presentations.</td>
<td></td>
</tr>
<tr>
<td>I consent to take part in this research project.</td>
<td></td>
</tr>
<tr>
<td>I would like to receive a summary copy of the research results</td>
<td></td>
</tr>
<tr>
<td>I understand that I will be given a copy of this signed consent form.</td>
<td></td>
</tr>
</tbody>
</table>
I consent to take part:

Participant Name:

Signature:

Date:

----------------------------------------------------------------------------------------------------------------
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TO BE COMPLETED BY RESEARCHER on attendance at the meeting:

I can confirm that I have explained to the above-named participant the nature of this study, and I have given adequate time for any questions to be asked and answered regarding the study.

Signed ................................................................. Date

.....................

Name (in capitals) ..........................................................

Post

..........................................................
Appendix 4. Interview Topic Guide for knowledge managers

1. Welcome & Introduction and consent form

2. Background/Context/Setting the Scene
   - What is your job? (very briefly)
   - Do you work with the public health commissioners in Rosetown? What do you do as part of this process?
   - How does commissioning work in Rosetown?

3. Evidence gathering
   - Do you gather evidence for decision making around the commissioning of public health services in Rosetown?
   - What sorts of evidence do you gather for the decision making?
   - How do you access them? What sources do you use for accessing evidence?
   - How frequently do you access different sources?
   - For whom do you access evidence?
   - For which topics?

4. Evidence formatting
   - How do you collate the evidence you source? Is it ready-made and fit for purpose or do you have to re-work it to make it useful?
   - Do you reformat or re-interpret evidence?
If so, what factors do you take into account when reformatting evidence (local context and knowledge, own experiences and expertise, etc.)

5. Evidence dissemination

- How do you pass on the collated evidence?
- To whom do you pass on the collated evidence?
- Which media do you use to disseminate evidence?
- How is this evidence used in your experience? Have you seen any changes occurring in the decision making process as a result of the evidence you provided?

6. Any other questions?

- Is there anything you would like to add that has not been covered in the interview?
- Is there anyone else you think we should interview in this study?

7. Recap & Closure. Thank you for your time. If we wanted to come back and talk to you again would that be OK (maybe by phone)?
Appendix 5. Interview consent form - The Participant Information Sheet

Project Title: Research Use and Knowledge Mobilisation in the Commissioning and Planning of Public Health Services - what helps and hinders - a study in the co-creation of knowledge

Introduction

You are being invited to take part in a research study. Before you make a decision, it is important for you to understand why the research is being done and what it will involve. Please take time to read this information carefully, and discuss it with others if you wish. Please contact the research team (our details are at the end of this information sheet) if there is anything that is not clear, or if you would like more information. Please take time to decide whether or not you wish to take part.

Thank you for reading this.

What is the purpose of the study?

This research is being conducted by a research team from the Universities of Teesside, Sunderland and Durham.

We will follow a public health commissioning team in England and a joint public health planning team in Scotland as each develops public health interventions from planning to delivery to see:

• How research is used – when, where, by whom and why
• How applicable research is identified and what other knowledge is considered
• Whether research is utilised differently when making bigger changes in comparison to smaller changes

We will use interviews to explore the views of those who put public health services into place, their senior colleagues, service providers, and those staff responsible for getting others
to use research evidence. This will provide a detailed and realistic view of how things happen in different places – identifying factors that help or hinder the use of research evidence in public health commissioning.

We also want to observe meetings where commissioning and joint planning decisions are taken to see how different types of evidence, information and data are used in practice.

Why have I been chosen?

As a member of staff involved in research utilisation or the commissioning or joint planning or provision of alcohol interventions your views are important. As part of this research the research team need to interview a sample of staff associated with the process of commissioning, planning, or providing alcohol interventions to explore their views on the use of evidence and research in service planning and delivery. You and other people involved are being asked if you would like to take part in face to face, semi-structured interviews. We may also wish to observe the meetings you plan these services in and if we do we will approach you separately for this.

Do I have to take part?

It is up to you to decide whether or not to take part. Whether or not you take part should be your decision and any identifying information about those taking part will be kept confidential and not discussed with your managers. Members of the research team may have previously been in contact with you during our earlier meetings with your organisation and talked to you about the project and taking part. We have sent you this information sheet and a copy of a consent form so that you can read these in advance and the research team are very happy to answer any questions you might have about the project or your involvement in this. When we meet you will have a further opportunity to ask questions and if you are happy to participate in the project you will be asked to sign a copy of the consent form. If you decide to take part you are free to withdraw at any time without giving a reason (we will keep the data collected so far from you and the group you work with). A decision to withdraw at any time, or a decision not to take part, will not affect your position in the workplace.

What will happen to me if I take part?
Our approach to this research is to work with our research participants in partnership. We hope to meet you and get to know you a bit as the project begins, so we are not strangers when we come to interview you, or observe your meetings.

Interviews

A member of the research team will contact you to arrange a convenient time and place to meet with you for a face to face, semi-structured interview. You may see the types of questions we will ask in advance if you wish. Before the interview the researcher will explain the research study to you and give you time to ask any questions and ensure that you definitely wish to take part. The interview will be audio recorded (with your permission) and will last around 45 minutes to an hour. During the interview you will be asked for your views on the use of research evidence within public health service commissioning, and your experiences of being involved in the planning, development and delivery of public health interventions. Some people who take part in these interviews will also be asked to take part in 2 or 3 additional interviews (which might be conducted via the telephone) during the 18 months following the initial interview. The data gathered from all interviews will be analysed by the research team and used in written reports, conference presentations and academic publications. We may use direct quotations (and you may recognise your own comments) but others should not be able to recognise you.

Observing meetings

It will be helpful for the research team to observe the meetings you hold so we can see how research evidence and other types of information and intelligence are used in practice. This would mean that one researcher (who you will recognise) will sit-in on your meetings and taking some notes about information use and decision-making processes. They will not take part in the meeting in any way. If a sensitive issue arises you will be able to ask the researcher to stop taking notes, or temporarily leave.

We will only use these notes to help us understand more fully what types of information are used when PH planning decisions are made. In the meeting we will not take down any direct quotes, or make any reference to any individuals (or their organisations) – we are only
interested in the overall general issues about what makes research evidence easy or difficult to use and what happens because of this. The Chair of the meeting will have given permission for us to observe the meeting and we will, in addition, ask for your consent to observe the meeting.

Feedback and Data interpretation Meetings

If it is useful, we hope to hold feedback meetings with our research participants to share our early findings, as you may be interested in hearing what we find. In these meetings we simply want to share information with you for your interest and help us check our understanding and interpretations of the data with you. We hope this process will be helpful to you too, as it may allow you to make changes to your current practices, if you decide that this is important. Attendance at these meetings is entirely voluntary – we will let you know when they are happening. They will be on-site if possible.

Can I take part in one thing but not another?

Yes, for example you may wish to take part in the interviews and agree to meetings being observed but not go to the feedback meetings. The choice is entirely yours.

What will happen to the data and findings of the research study?

Before the interviews, participants will be asked if they are happy for the audio-recorded information to be used. If participants are happy for the information to be included, it will be analysed to identify the range of views of all those taking part and identify issues they raise. Any information you give will have identifying details such as your name or occupational role removed so that you, others, (and any organization) cannot be recognised from it.

Data will be securely stored following University and Data Protection procedures. The information you give will be seen by other researchers in the research team, but they will not know who you are. Audio tapes will be transcribed by a professional transcription service that is located in another part of the UK to protect the identities of those involved. There is a confidentiality agreement in place between the external transcription service and the university. Interim reports and a final report will be produced representing participants’
views. Direct quotations from interviews may be used in these reports, academic publications and conference presentations, however participants will not be named.

Will my taking part in this study be kept confidential?

Any interviews will be audio recorded (with your permission). Any information which may identify the person taking part in the interview will be removed at the point of transcription. Observation field notes will be anonymised. The anonymised files, transcripts and field notes will be stored securely by Teesside University for ten years after the end of the research study – then the files will be destroyed.

Who is organising and funding the research?

The project is being carried out by a research team from the Universities of Teesside, Sunderland and Durham. It is funded by the National Institute for Health Research Health Services and Delivery Research (NIHR HS&DR) programme. The NIHR HS&DR is a research funding body that strives to produce and promote the use of research evidence about how the organisation and delivery of services can be improved to increase the quality of patient care, ensure better strategic outcomes and contribute to improved public health. The project is being hosted by Teesside University who will also act as sponsor.

Who has reviewed this Study?

This study has been externally reviewed by the funding body (above). It has also been reviewed internally within Teesside and Durham Universities to check that it adheres to its research and governance procedures. The research is registered with the relevant NHS R&D departments.

What do I have to do – what happens next?

If you do decide to take part please reply to this message simply saying ‘YES’. Similarly, if you do not wish to participate please reply with a ‘NO’ so that we know not to contact you any further.

Thank-you for your time in reading this.
Contact details
If you would like any further information, please contact either:

Dr Mandy Cheetham (Research Associate)
School of Health and Social Care,
Parkside West,
Teesside University,
Middlesbrough,
TS1 3BA, UK
By phone on: 01642 342989 or via email at m.cheetham@tees.ac.uk

Further information about the study is available from the Principal Investigator:
Professor Rosemary Rushmer
Professor in Knowledge Exchange in Public Health
School of Health and Social Care,
Parkside West,
Teesside University,
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TS1 3BA, UK
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Professor Carol Tannahill, Dr Pete Seaman and James Egan (Glasgow Centre for Population Health)
Mr Liam Hughes (previous of the Local Government Improvement and Development)
Appendix 6. The lay summary for research participants

Working Title: Research use in public health planning and commissioning for alcohol interventions

Full title: Research use and knowledge mobilisation in the commissioning and planning of public health services - what helps and hinders - a study in the co-creation of knowledge

Funder: National Institute for Health Research: Health Service and Delivery Research (NIHR:HS&DR)

Duration: 2 years (start: Dec 2011). Proposed fieldwork dates: April 2012- May 2013

Principal Investigator: Rosemary Rushmer, Teesside University r.rushmer@tees.ac.uk
Co-Applicants: David Hunter (Durham University); Ann Crosland (Sunderland University); Joanne Gray (Northumbria University); Carol Tannahill (Glasgow Centre for Population Health GCPH); Peter Seaman (GCPH); Liam Hughes (LGG).

Lay Summary
Services based on research evidence of what works lead to better patient outcomes. In public health (PH), evidence of what works well may not be available, or not apply in all settings, making it difficult to know precisely what services to support for the best outcomes. We do not know if research evidence is used well to create public health services and if NHS managers support this. What services are put in place are likely to depend on many things i) what evidence is available and brought into play; ii) what stakeholders want (managers, practitioners, the public, the government); and iii) whether the manager can commission (buy) specified services or jointly plan and agree services collaboratively with other partners.

Case Studies
NHS structures and the places in which public health commissioning takes place will be changing as this project unfolds. We will need to take a flexibly approach to what we mean by ‘case study sites’. We will follow the commissioning (and joint planning) of an alcohol-related service or intervention, and ‘follow-the-action’ across whichever organisations are involved in securing these services / interventions. An alcohol-related service or intervention has been picked for 3 main reasons: i) as a cross-cutting issue it is likely to ‘pull-in’ multiple agencies, ii) it’s high-profile suggests that it will remain a priority regardless of current reforms, and iii) having one-overarching topic will allow us to compare across case studies. We will begin in a Primary Care Trusts in England (commissioning) and a Health Board in Scotland (joint planning) as they put one alcohol development in place from start-to-finish, planning to delivery. The final choice of which alcohol-related service or intervention will be decided in agreement with our case study sites.

The access we need:
We will want to see: i) how research is used (when, where, by whom and why); ii) how applicable research is identified and what other knowledge is taken into account (e.g. local expertise, traditions) iii) if making big changes (perhaps removing services) gets evidence used in different ways to when small changes are made (tweaking existing services). We will
gather information by: **interviewing** those who work to put public health services in place; their senior colleagues; and perhaps those on the receiving end of their work (service providers; the public) to explore views; we will **observe behaviour and activity in planning meetings**; we will read through any **documents** produced by these meetings and other written material that informs the process (policy documents and other guidance). We will also interview NHS (or other) staff (who (do not work in public health but) have a direct responsibility for getting others to use research evidence to understand the challenges they face. Finally, we will **look at figures collected** (routine datasets) to see if the use of research evidence seems to make a difference to the performance of the NHS (against targets, commissioning competencies, patients’ views). This will give us a detailed and realistic view of how things actually happen in different places - to spot things that help or hinder the best use of research evidence.

What our research participants get:
Our overall approach is to **work with** our research participants to identify questions they would like answers to and **regularly share findings** with them - to help them to change practices if they wish. We will offer regular feedback meetings and invite comment on early findings, to get a shared view of how best to understood the issues and if they are important or not. This is a relatively new way of doing research in healthcare settings and we hope to learn as we go along how to do this well. To **see if our findings are typical and apply elsewhere** we will design a 2-stage Delphi questionnaire for issue to interested stakeholders and invite them to a **national workshop** to share and discuss our findings and invite comment. As well as **publishing in academic journals** (and perhaps jointly in more practice-oriented publications) and presenting at conferences, **we will work hard to share our findings more widely**. We will send **one-page summaries** to all who took part in our study and (if permitted) through certain managerial websites and professional networks. This work will take 2 years to complete.

Research Governance and Research Ethics Committee Approval
There 3 main ethical issues in our study i) participants give-up their time to take part, ii) some issues may be sensitive; iii) by sharing our results as we go along we are intervening in NHS business. By strictly protecting confidentiality and sharing findings on joint research questions to produce timely change we hope this makes taking part worthwhile. Our study will be /has been reviewed through the national research ethics process (GAfREC) and is undertaken in compliance with the R&D and governance processes of the NHS. Prior to this the study was externally reviewed by the National Institute for Health Research Service & Delivery Organisation (NIHR:HS&DR) who fund this project. In addition to this the project has been internally reviewed within Teesside University and approved by its own research ethics committee. Details of the project can be found on the NIHR website.

The research team is well placed to carry out the work as we bring i) the necessary research skills and experience to collect that data: qualitative (interviewing, observation, narrative analysis); quantitative skills (interrogating routine datasets; statistical processes); ii) expertise and knowledge in public health settings and healthcare policy to interpret the data iii) membership of networks and NHS (and local government bodies) through which to engage case study sites and share findings.
For further details you can contact:
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TS1 3NN, UK
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Appendix 7. The word version of the Delphi questionnaire

Have your say…

- Below are 11 questions (3 pages).
- The questions are about how you use evidence in your decision-making at work
- There are no right or wrong answers – we are only interested in what you think
- Confidentiality: results will be aggregated with no personal identifiers.

Instructions for Completion
There are two statements on each line – please place an X in one of the boxes along the line which, on balance, represents your view on both statements.

The closer your X is to the statement at one end of the scale then the more you agree with that statement and the less you agree with the statement at the other end.

EXAMPLE

<table>
<thead>
<tr>
<th></th>
<th>Not</th>
<th>Somewhat</th>
<th>Very</th>
</tr>
</thead>
<tbody>
<tr>
<td>I like the mountains</td>
<td></td>
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<tr>
<td>X</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>I like the sea</td>
<td>X</td>
<td></td>
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</tr>
</tbody>
</table>

Place an X in one box at the end of each line to say how important you think the issue is.

After completing the questionnaire, please save this document and return to HSCL@tees.ac.uk by 30th September 2013

Thank you
PLEASE TURN OVER -
On balance, place your X to reflect which statement you agree with most (CLICK ON A BOX) Clicking the middle box will show you equally agree with both

<table>
<thead>
<tr>
<th>Statement</th>
<th>Not Important</th>
<th>Somewhat Important</th>
<th>Very Important</th>
</tr>
</thead>
<tbody>
<tr>
<td>I find national evidence most useful in my decision-making on Public Health issues</td>
<td>☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐</td>
</tr>
<tr>
<td>I typically go to one trusted source of evidence</td>
<td>☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐</td>
</tr>
<tr>
<td>It’s people that make sure evidence is drawn into decision-making in my organisation</td>
<td>☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐</td>
</tr>
<tr>
<td>Most of the evidence “speaks for itself”</td>
<td>☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐</td>
</tr>
<tr>
<td>The most valuable knowledge comes from practical experience</td>
<td>☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐</td>
</tr>
<tr>
<td>Commissioning across a purchaser-provider split makes it easier to secure evidence-informed interventions</td>
<td>☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐</td>
</tr>
<tr>
<td>Public Health should be focussed on changing national policy</td>
<td>☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐</td>
</tr>
<tr>
<td>Research evidence best informs strategic planning</td>
<td>☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐</td>
</tr>
<tr>
<td>Research evidence ‘trumps’ politics</td>
<td>☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐</td>
</tr>
<tr>
<td>The health of the population is most important when making decisions</td>
<td>☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐</td>
</tr>
<tr>
<td>Research evidence should be produced</td>
<td>☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐</td>
<td>☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐</td>
</tr>
</tbody>
</table>
Any comments or questions you would like to add? Any suggestions for improving the use of evidence in decision making?

Click here to enter text. Click here to enter text.

PLEASE TURN OVER - REGISTER OVERLEAF
Details and Registration

Please provide us with the following information:

Job title: Click here to enter text.
Organisation: Click here to enter text.
Work Location: Click here to enter text.

If you would like to register for the free national seminar on 5th November 2013 in Darlington, please leave your name and email address (see flyer):

Name: Click here to enter text.
Email address: Click here to enter text.

Results of this questionnaire will be shared and discussed at the workshop – we are keen to hear what you think.

Thank-you

The Research Team,
“Research utilisation and knowledge mobilisation in the commissioning and joint planning of interventions to reduce alcohol related harms – a study in co-creation”
August 2013

See also attached:
- National workshop flyer and
- Lay-summary of the project

For more information contact:
P.Van.Der.Graaf@tees.ac.uk

Acknowledgements

HS&DR Funding Acknowledgement:
This project was funded by the National Institute for Health Research Health Services and Delivery Research Programme (project number 09/1002/37).

Department of Health Disclaimer:
The views and opinions expressed therein are those of the authors and do not necessarily reflect those of the HS&DR Programme, NIHR, NHS or the Department of Health.
Appendix 8. Briefing sheet on working together in the co-creation of knowledge

Title: Research Evidence Use in the Commissioning of Alcohol Services and Interventions

Co-creation - working together on the project –
This short document will help explain what is involved in jointly researching how evidence is used in the commissioning of alcohol services and what we can expect from each other

Before the project begins we would like to:
- Meet each other (faces to names…)
- Agree which ‘alcohol area’ to research – so any findings are useful and timely for you.
- Explain what we will do (data collection), when, where & how often, so that is acceptable.
- Begin to identify the first people to contact
- Establish our ‘adoptive family’ – 2-3 people (involved in the area) who will work with us more closely (see below).

As the project progresses
We will be on site for a few days each month between April 2012-March 2013 with some updates until November 2013 when the project ends.
- We will want to interview staff involved, observe commissioning meetings and read the documents involved in that alcohol commissioning process; access any routinely collected data you have on the process. (We will look at other routinely collected data on your organisation held externally).
- Meet our ‘adoptive family’ regularly, to share and discuss early findings, and check our understanding.
- You may (or may not) want to add 1-2 questions of your own for us to explore or take an active part in data collection. This is entirely your choice.

We will
- Explore the organisational processes that help or hinder the use of research evidence.
- Be available to answer questions.
- Respect the confidentiality of all staff and the organisation.
- Seek informed consent from those taking part and be sensitive to practice needs
- Share findings with our ‘adoptive family’ regularly – so you can act on them if you wish.
- Offer you opportunities to: share results with our other case study site and an invited national audience; jointly publish and present findings at conferences; disseminate findings across your networks.
- Offer you input to the final report, and briefing summaries for your use.

More details about the project
Members of the research team are: Professor Rosemary Rushmer (Principal Investigator Teesside University r.rushmer@tees.ac.uk); Ms Karen Smith (Research Associate Sunderland University karen.e.smith@sunderland.ac.uk). Dr Mandy Cheetham, Teesside University.
Other co-applicants are: Professor Ann Crosland (Sunderland University); Professor David Hunter (Durham University); Dr Joanne Gray (Teesside University); Professor Carol Tannahill, and Dr Rosie Ilett (both Glasgow Centre for population health); Lynda Cox (the NE SHA) and Liam Hughes (formerly the Local Government Group). External members of our advisory group are: Professor Cam Donaldson (Glasgow Caledonian University); Dr Crispin Coombs (Loughborough University); and Dr Claire Sullivan (NHS county Durham and Darlington).

Professor R Rushmer
February 2012

Early tasks
1) Discussion with senior level people

2) Initial discussion and scoping of topic
   - Alcohol-related
   - Something which will be useful to you
   - Identification of who should be involved
   - Contacts for meetings and interviews, including Chief Knowledge Officers or knowledge transfer leaders

3) Identification/establishment of a small team (2-3 people) who have an interest in that area to work as a joint interpretation group (meet/report back every 2-3 months).

4) Assistance with identifying relevant staff

5) Access to relevant documents

6) Agreement to observation of meetings (and consent in principle)

7) Interviews with key stakeholders early on in project

Fieldwork
How often?

1) Permission required for
   - Interviews with stakeholders involved in commissioning and/or knowledge exchange and research utilisation
   - Observation of meetings related to commissioning or joint planning in chosen topic area
   - Access to documents used in and related to process

2) Interviews and other onsite work arranged around meetings to reduce recurrent disruption for your staff and enable researchers to make efficient use of visits.

Joint interpretation group
A small group of 2-3 people who are sensitised to local and organisational issues and are willing to work more closely with the researchers to:
- Provide advice and guidance
- An awareness of context and sensitive issues
- Act as a first point of contact on-site
- Be involved in regular (every 2-3 months) feedback meetings in order to feedback on findings, help interpret findings and check/clarify our understanding.
- Take action if needed

What is expected of participants?

Two strands: staff involved in commissioning and staff who have the role of providing evidence.

1) Commissioning staff
- An interview
- Observation of some relevant meetings
- Possibly 2-3 follow-up interviews (which may be done by phone)

2) Evidence-providing staff
- One (possibly more) interview
**Appendix 9. Quantitative Data for Alcohol Licensing in Thistletown**

Scoping the Quantitative Data for Alcohol Licensing in Thistletown.

In order to ascertain the extent of alcohol licensing as a public health problem in Thistletown, a scoping exercise was undertaken in order to identify potential/relevant quantitative data sources. This took place between January – August 2013. The table below highlights points of contact and a summary of available data sources.

<table>
<thead>
<tr>
<th>Data Source</th>
<th>Data Domains</th>
<th>Data Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Scotland</td>
<td>Alcohol related Admissions and Deaths by Intermediate Zone and Community Health Partnership/Sector</td>
<td>Cross sectional data 2011 and 2012.</td>
</tr>
<tr>
<td></td>
<td>Health &amp; Well Being Survey</td>
<td>Alcohol consumption levels</td>
</tr>
<tr>
<td>The Scottish Public Health Observatory (ScotPho)</td>
<td>Scottish Health Survey (2012)</td>
<td>Self reported answers to annual questionnaire</td>
</tr>
<tr>
<td></td>
<td>Alcohol Profiles</td>
<td>Epidemiological data comparing local alcohol profiles with Scottish national averages.</td>
</tr>
<tr>
<td>Information Services Division Scotland</td>
<td>Alcohol Licensing statistics by area</td>
<td>Personal and premises licenses granted and refused 2010-11 and 2011-12</td>
</tr>
<tr>
<td>Literature</td>
<td>Various peer reviewed academic papers and evaluation reports</td>
<td></td>
</tr>
</tbody>
</table>

Table 1: Summary of the available data sources for Thistletown

Results of the Scoping Exercise

The results of the scoping exercise suggest that there is robust and reliable evidence regarding the extent of alcohol licensing and the social, economic and health impact of this at a national and international level. A range of local data exists relating to Thistletown including alcohol consumption, alcohol related events and licensing data for Thistletown. However, data regarding outlet density in Thistletown was not available. The research team requested licensing data by area from the licensing board but unfortunately, we were unable to obtain this due to resource constraints within the council. This could have enabled us to analyse the relationships between licensing behaviour/outlet density for distinct geographical areas of
Thistletown and the impact of this on for example, health related events. However, in light of this lack of detailed licensing data, we had to rely on other data sources. These are highlighted in the table above and include health related evidence from the NHS in Thistletown and the licensing statistics provided by Information and Statistics Division of the Scottish Government and the academic evidence base.

Scoping Exercise: Data Analysis.

Alcohol Consumption in Scotland.

Results from the Scottish Health Survey (2012) suggest that alcohol consumption levels in Scotland have declined from 2003. Average unit weekly consumption has fallen since 2003. In 2012 men drank an average of 4.6 units less per week than in 2003 (19.8 units in 2003 and 15.2 units in 2012). Average unit consumption for women declined from 9.0 units per week in 2003 to 7.6 units in 2012. Furthermore, a quarter of men and 18% of women drank at hazardous or harmful levels (more than 21 units per week for men and more than 14 units for women) in 2012. Hazardous or harmful drinking prevalence has also declined since 2003 although levels did not change significantly between 2011 and 2012. One in five (19%) adults in Scotland exhibited signs of a possible alcohol use disorder according to their scores on the Alcohol Use Disorders Identification Test (AUDIT) screening tool, with men significantly more likely than women to do so (25% compared with 13% of women). Men in low income households were more likely than those with higher household incomes to display signs of harmful drinking or possible alcohol dependence based on the AUDIT score (11% compared with only 2% in the highest income quintile). When compared with men living in Scotland’s least deprived areas (Scottish Index of Multiple Deprivation (SIMD) quintile 5), those living in the 20% most deprived areas (SIMD quintile 1) were significantly more likely to exhibit signs of a potential alcohol use disorder (32% versus 21%).

Alcohol Related Hospital Events in Scotland.

Alcohol is a significant problem in Scotland in terms of morbidity, mortality and social harm but although alcohol related events are high, there has been a downward trend in recent years. In 2011/12, there were 38,737 alcohol-related discharges from a general acute hospital in Scotland (a rate of 691 discharges per 100,000 population). Encouragingly, this is a 0.5%
decrease in absolute numbers compared to the previous year (2010/11), when there were 38,924 alcohol-related discharges (a rate of 709 discharges per 100,000 population). Furthermore, over the last five years, there has been a 14% decrease in rates of alcohol related discharges from a general acute hospital in Scotland; from 802 discharges per 100,000 population in 2007/08 to 691 discharges per 100,000 population in 2011/12. The largest decrease was in the 45-49 year age group and the second-largest decrease in those aged 15-19 years. For people aged 40-44 years the rate increased from 2010/11 to the latest year (also very small increases were seen in these aged 20-24, 25-29 and 30-34 years of age), although since 2007/08 their rates have dropped markedly as well. However, between 2007/8 and 2001/12, the rate of alcohol-related general acute hospital discharges was approximately seven times greater for patients living in the most deprived areas compared to those living in the least deprived areas. (ISD 2013)

Alcohol Related Hospital Events in Thistletown.

The rate of alcohol-related discharges from general acute hospitals in Scotland varied greatly between NHS Boards between 2007-8 to 2011/12. In the latest year (2011/12) the discharge rate in Thistletown was in the top 5 highest with 1,012 discharges per 100,000 population. Throughout the 5-year time period Thistletown was one of two HBs that recorded the highest alcohol-related discharge rates. However, both recorded an approximately 9% decrease in discharge rates from 2007/08 to 2011/12. In their alcohol profile, the Scottish Public Health Observatory (ScotPho) also suggests that alcohol related mortality and prevalence of problem drinkers is significantly worse in Thistletown than the national averages for Scotland.

Alcohol consumption in Thistletown.

A piece of national research (reference withheld) found, in a survey of residents in 15 relatively deprived communities in Thistletown, that 27% of men and 14% of women respondents reported levels of drinking over the weekly recommended amount. The local NHS Health and Wellbeing Survey in 2011 reported that just under half (45%) of respondents drank alcohol weekly. One in five (20%) respondents had exceeded the recommended weekly limit for alcohol consumption in the previous week. Three in ten (31%) respondents had been binge drinkers in the previous week.
Relationship between alcohol availability, consumption and harm.

Availability of alcohol concerns the ease and convenience with which it can be obtained. The relationship between the physical availability of alcohol in society and levels of alcohol consumption and harm has been explored in a large number of research studies from different countries. MacNaughton & Gillan in their report “re-thinking alcohol licensing” suggest that there is strong and repeated evidence that shows that increasing access to alcohol, through more outlets and longer trading hours, affects a range of alcohol-related harms and in certain circumstances, levels and patterns of consumption. They suggest that overall, the weight of evidence supports a conclusion that restrictions on the availability of alcohol can contribute to a reduction in alcohol-related problems.

Relationship between alcohol outlet density and alcohol related problems.

A substantial number of studies have examined the relationship between outlet density (number and type of outlets) and a variety of alcohol-related problems. (Barbor et al 2010) The clearest evidence of a relationship comes from natural experiments in countries where large scale policy changes have been implemented over a relatively short time period. Two recent studies from Canada assessed the impact of privatisation of government-run liquor stores on consumption and harm following a 33.4% increase in the number of private liquor stores in British Columbia between 2003 and 2008. The research found increasing density of liquor outlets associated with a rise in alcohol sales per head of population, as well as a 27.5% increase in the alcohol-related death rate per 1000 residents for each extra private liquor store (Stockwell et al 2009; 2011).

Evidence consistently shows a link between areas of high outlet density and increased risky drinking and alcohol-related harm, particularly violence. A recent systematic review found 44 studies showing significant positive relationships between the density of outlets and levels of violence, alcohol related traffic accidents, self-reported injuries and suicide, sexually-transmitted disease and child abuse or neglect (Popova et al 2009). An association between outlet density and domestic violence was found in a study from Australia that assessed whether changes in outlet density at a post-code level were related to changes in domestic violence rates over a ten-year period. The study showed a 28.6% above-average increase in the domestic violence rate for each additional ‘packaged liquor’ outlet per 1000 residents in a
postcode (Livingston 2011). A recent English study found a positive relationship between density of off-licensed premises and alcohol-related harms amongst under-18s. The study demonstrated that nearly 10 per cent of all alcohol-specific hospital admissions in England, excluding London, could be attributed to off-licence density, with every two extra off-licences per 100,000 of population resulting in one alcohol-specific hospital admission of an under 18-year-old per 100,000 (Coghill 2011). A study by Chiang (2010) analysed the relationship between licensed premises and alcohol related crime across the entire geographical area of the NHS near Thistletown. The findings suggested a strong positive relationship between the number of premises in a geographical area, the proportion of young people aged 16-24 years and the occurrence of crime.

Association between alcohol consumption, alcohol availability and socioeconomic status.

Evidence of an association between alcohol consumption, alcohol availability and socioeconomic status remains inconclusive, overall. However, alcohol availability (measured by access to shops and restaurants which sell alcohol) may help to explain the link between neighbourhood deprivation and harmful alcohol consumption. Neighbourhood deprivation has been associated with the number of alcohol outlets, with more outlets in poorer areas; and studies have shown that a higher density of alcohol outlets is associated with increased rates of youth drinking and driving, assault, violence and homicide, rates of injury and rates of traffic collisions and traffic injuries (Scribner et al., 1994, 1995; Treno et al., 2001; Gruenewald et al., 2002). Studies at the city level, mainly in North America, have suggested that the density of alcohol outlets may be higher in poorer neighbourhoods (Pollack et al., 2005). Studies across nations (New Zealand) have shown a similar pattern, with greater access to alcohol outlets in more deprived urban areas (Hay et al., 2009). A recent Scottish based study by Ellaway et al., (2010) investigated the distribution of alcohol outlets by area level deprivation across a large Scottish conurbation. A list was created of alcohol outlets with street addresses obtained from the City Council in 2006, including seven categories of outlet ranging from public houses, off-sales, restaurants and bars to private members and entertainment clubs (bingo halls, nightclubs and concert halls). All alcohol outlets were mapped and proximity to nearest outlet calculated across quintile of area deprivation. The analysis included 2221 alcohol outlets across the city. The study reported that the socio-spatial distribution of alcohol outlets across the conurbation does vary by deprivation but not
systematically. Some deprived areas contain the highest concentration while others with a similar deprivation score contain very few. Within Thistletown three areas have the greatest level of alcohol outlets per 1000 population. The most deprived areas in the east end of the inner city, have the second greatest number of off-sales. The Thistletown’s four main peripheral housing sites did not have a high density of alcohol outlets of any kind. This study suggests that there is a less consistent association between the density of alcohol outlets and deprivation in Thistletown, findings similar to the studies carried out in North America and New Zealand.

Data on alcohol licensing.

In 2010-11 there were 16,377 premises licenses and 40,266 personal licenses in force in Scotland. Of these, 10.5% (1715) of the premises licenses and 12% (4832) of the personal licenses were in force in Thistletown, which is very similar to the number and type of outlets in Scotland’s other urban centres. Similar figures were also relevant for 2011-2012. The following table shows premises licenses that were granted and refused under section 23 and personal licenses that were granted and refused in Scotland as a whole, another urban centre, Thistletown and a more rural setting close to Thistletown in 2010-11 and 2011-12.

<table>
<thead>
<tr>
<th></th>
<th>Scotland as a whole</th>
<th>Thistletown</th>
<th>Other Scottish urban centre</th>
<th>Rural setting near Thistletown</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2010-11</td>
<td>2011-12</td>
<td>2010-11</td>
<td>2011-12</td>
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<td>Premises Licenses Section 23</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refused</td>
<td>10</td>
<td>21</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Granted</td>
<td>327</td>
<td>354</td>
<td>66</td>
<td>50</td>
</tr>
<tr>
<td>Personal Licenses section 72</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refused</td>
<td>28</td>
<td>17</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Granted</td>
<td>5886</td>
<td>5282</td>
<td>680</td>
<td>683</td>
</tr>
</tbody>
</table>

Table 15: To show the number of licenses granted in various areas of Scotland 2010-12

Of the total premises licenses granted in Scotland in 2010-11 and 2011-12, there was a reduction from 20% to 14% granted in Thistletown respectively. In terms of licenses refused as a proportion of the total figures in Scotland there was an increase in refusals in Thistletown
from 2010-11 to 2011-12 with a rise from 10% to 38%. These figures are for 2 years only therefore it would be difficult to suggest any improvement in terms of overprovision would be misleading, but the figures for 2011-12 are certainly more encouraging. This picture however, is not mirrored in the number of personal licenses refused as there were no refusals in both years in Thistletown.

Summary of the evidence: Alcohol outlets and drinking behaviours in general and in Thistletown.

There is no clear patterning of average alcohol consumption levels by area level deprivation. However there is a pattern of increased alcohol related morbidity and mortality by area level deprivation (higher levels of alcohol related diagnoses in more deprived areas). The density of alcohol outlets is an important factor not just in relation to drinking levels but also in relation to other forms of alcohol-related harms, especially rates of assault and increased violence. There is no clear pattern of alcohol outlet density and area deprivation in Thistletown, but some of the most deprived areas have amongst the highest number of alcohol outlets, in particular in the East End of the city. Rates of alcohol-related morbidity and mortality remain to be analysed alongside data on alcohol outlet density for small areas.

Evidence regarding the use of evidence by Licensing Boards.

MacNaughton & Gillan in their report “Re-thinking alcohol licensing” suggest that there is limited interpretation of the licensing objectives in licensing board policy statements. They suggest that this is perhaps in part a reflection of the newness of policy formulation for boards and the process of systematically gathering evidence, interpreting it, and then developing a policy position based on the evidence and in relation to the objectives. They reviewed that first batch of published policy statements and found that evidence sources are not routinely cited, nor is there always a clear line of reasoning from the evidence to the policy position adopted. Furthermore, in determining overprovision, they found that 14 boards gave no information on statistics used or individuals/groups consulted; 14 specifically listed the police as a consultee, attesting to a continued licensing emphasis on public order problems; and four listed the licensing forum. Only one board listed the NHS and just one listed an alcohol and drug partnership. A lack of local data relating to the licensing objectives was sometimes highlighted in this regard. They argue that whilst it is arguably the
case that data on alcohol-related consumption and harm could be made more easily accessible and usable, a lot of local data exists that are not currently utilised by most boards or if referred to are not translated into policy action. They found that one licensing board’s policy statement was a notable exception in demonstrating a systematic approach to gathering and analysing evidence and translating evidence into policy positions that related to the licensing objectives. The authors suggest that the patchy use of evidence of alcohol-related harm in policy statements is perhaps indicative of the degree to which licensing boards have traditionally operated in isolation from other Public Health and could therefore be symptomatic of a lack of integration between licensing policy and other public policies on which licensing matters pertain.

Support and guidance for licensing boards.

An evaluation of the implementation of the objectives of the Licensing (Scotland) Act 2005, recently published findings of a study of the implementation of the Licensing (Scotland) Act 2005, undertaken as part of the national monitoring and evaluation of Scotland’s alcohol strategy (MacGregor et al 2013). The report confirms some of the problems licensing officials have identified trying to give meaningful effect to the public health objective. Amongst a number of issues raised by licensing officials is a perceived lack of guidance in how to address the public health objective and a view that it is too wide in scope and therefore too difficult to define and measure. The findings identify the need for more support and guidance for licensing authorities in fulfilling their duties under the 2005 Act. Specifically, more guidance to be given to Boards on how to address the public health objective in their policy statements and more generally, the objective to be more clearly defined and advice given as to which datasets to use or indeed develop in the future.
Appendix 10. Quantitative Data for Alcohol consumptions and pregnancy in Rosetown

FASD: Difficulty in estimating prevalence.

Exact numbers are difficult to define in this spectrum of disorder and there are no accurate figures for prevalence in the UK. This is due to a number of factors, including the differing definitions and conditions along the spectrum, the poor accuracy in self-reporting of alcohol consumption, lack of standardisation of levels of drinking, reluctance to make or accept the diagnosis, and paucity of reliable data collection. Most figures come from the USA, where it is estimated that FAS occurs in 0.5-2 live births per 1,000 and fetal alcohol spectrum conditions occur at least three times as often as this.[2]

Scoping the Data for Drinking in Pregnancy in Rosetown.

In order to ascertain the extent of the problem regarding drinking in pregnancy in Rosetown, a scoping exercise was undertaken in order to identify potential/relevant data sources. This took place between January – August 2013. The table below highlights points of contact and a summary of available data sources.
<table>
<thead>
<tr>
<th>Data Source</th>
<th>Data Domains</th>
<th>Data Features</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rosetown LA/PCT data</td>
<td>HRG inpatient data</td>
<td>035.4 – suspected damage to the foetus related to alcohol P04.3 Foetus and newborn affected by maternal alcohol use Q86.0 foetal alcohol syndrome</td>
<td>Obtained but biased due to problems with coding</td>
</tr>
<tr>
<td>Organization</td>
<td>Type of Data</td>
<td>Details</td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Rosetown Integrated Commissioning for Addiction and Offender Health</td>
<td>As above</td>
<td>Obtained as above</td>
<td></td>
</tr>
<tr>
<td>Rosetown University Centre for Public Health</td>
<td>Monitoring data for the commissioning group</td>
<td>Same as LAPE data provided by Rosetown Public Health Observatory</td>
<td></td>
</tr>
<tr>
<td>Rosetown Hospital</td>
<td>A&amp;E data</td>
<td>No data</td>
<td></td>
</tr>
<tr>
<td>Rosetown Mental Health Trust</td>
<td>In patient data</td>
<td>Data unreliable due to data collection and coding within A &amp; E</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Psychiatric Liaison</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Community Teams (inc. monitoring data from Rosetown Community Alcohol) Service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rosetown Ambulance service</td>
<td>Alcohol related calls</td>
<td>No data</td>
<td></td>
</tr>
<tr>
<td>Rosetown Maternity Hospital (foundation trust)</td>
<td>Socio-demographic data on women during pregnancy and a record of reported alcohol consumption from antenatal booking form.</td>
<td>Total number of births per annum, local data on FAS, numbers of women known to have alcohol/substance misuse issues in contact with midwives. Booking question numbers.</td>
<td></td>
</tr>
<tr>
<td>National Drug</td>
<td>No data</td>
<td>No additional data regarding alcohol</td>
<td></td>
</tr>
<tr>
<td>Treatment Monitoring System with Manchester University’s NDEC</td>
<td></td>
<td>consumption in pregnancy.</td>
<td></td>
</tr>
</tbody>
</table>

Table 16: To show the data sources consulted for data relating to maternal alcohol consumption in Rosetown
Following the scoping exercise, it can be concluded that there is no robust and reliable data available regarding alcohol consumption in pregnancy neither from a local or national perspective. The most reliable data concerning alcohol misuse and its associated consequences are the local alcohol profiles for England produced by the North West Public Health Observatory (NWPHO) which is now part of Public Health England (PHE). The NWPHO takes a lead role on alcohol intelligence on behalf of PHE.

The NWPHO has produced and published Local Alcohol Profiles for England on an annual basis since 2006. The latest update, Local Alcohol Profiles for England 2012, was released on August 16th 2012. The profiles contain 25 alcohol-related indicators for every Local Authority and 22 for every PCT in England. The indicators measure the impact of alcohol on local communities and include a national indicator generated by the DoH – Admission episodes for alcohol-attributable conditions (previously National Indicator 39).

Alcohol misuse has health and social consequences borne by individuals, their families, and the wider community. In 2006, the NWPHO and the Alcohol Research Team (Centre for Public Health, Liverpool John Moores University) gathered routine data and intelligence from a range of sources (including the DoH and the Home Office), to provide a national indicator set intended to inform and support local, sub-national and national alcohol policies. These indicators provided measures to help prioritise and target local areas of concern. In addition, they provided a baseline for monitoring progress in reducing alcohol-related harm at local, sub-national and national level.

During the compilation of the indicators, the NWPHO reviewed methods of deriving population measures of alcohol-related harm, selecting indicators and developing methods consistent with current knowledge and understanding, thus reflecting the wide range of domains that may be affected by alcohol misuse. However, none of these indicators are relevant to alcohol misuse in pregnancy and its associated consequences.

Another data source that has some use to the project is that provided by Rosetown Maternity Hospital. This includes patient level data on live deliveries by age, postcode, ethnic origin and reported alcohol consumption. However, this data is likely to be an underestimation of the alcohol consumption among young women or pregnant women, because it is self reported. Such reporting is unreliable because of poor estimation, poor recollection and the
social stigma associated with heavy drinking during pregnancy (ref Plant MA, Miller P & Plant ML, 2005). This situation is compounded by variations in the alcoholic concentration of different types of alcoholic drinks.

Data Analysis.

Alcohol Use.

Results from Rosetown Lifestyle Survey 2012-13 show that just over half of Rosetown adults drink (56%). Of those that do drink alcohol, 7 in 10 do so more than once a week, with most saying they do so 1 to 3 times per week (54%). Just fewer than 1 in 10 (8%) adults in the city who drink do so every day of the week.

The lifestyle survey also shows that among the adults in Liverpool who do drink, 15% drink above the recommended guidelines (increasing risk), with a further 6% drinking at high risk levels (greater than 50 units per week for men, and over 35 units per week for women). This equates to an estimated 30,150 and 11,300 residents respectively. Research shows that surveys can drastically underestimate the level of alcohol consumption. A study in Manchester by the Centre for Public Health at Liverpool John Moores University indicated that normal surveys underreported the amount of alcohol people say they drank by 33%, suggesting the prevalence of high risk drinking in Rosetown could be much higher than our lifestyle survey results suggest.

Alcohol Related Hospital Admissions.

Approximately 10% of all admissions in the city are estimated to be alcohol related, with approximately 15,000 alcohol related admissions each year. Alcohol related conditions include those specific to alcohol such as alcoholic liver disease or alcohol overdose and those conditions that are caused by alcohol in some but not all cases e.g. stomach cancer and unintentional injury. ECSS’s rate of hospital admission for alcohol related conditions is one of the highest in England. Latest figures available for Q2, 2012/13 show Rosetown was ranked in the highest 10 out of 326 LAs in England (Q2 2012/13). While alcohol related hospital admissions in the city remain high, figures indicate levels have plateaued in recent years, mirroring the pattern seen regionally and nationally.
Alcohol Related Mortality.

It is estimated that alcohol reduces life expectancy in Rosetown substantially, by 14.8 months for men and 7.6 months for women.

Approximately 80 Rosetown residents die each year from an alcohol specific condition, one third of who are females. In 2008-10 Rosetown was ranked in the top 10 highest out of 326 local authorities in England for its alcohol specific mortality among males and in the top 20 highest among females. The rate of alcohol-specific mortality in males was 25.5 per 100,000, a fall of 9% on the previous year and 12.1 per 100,000 in females, a fall of 13% on the previous year (LAPE 2011/12). Encouragingly the ECSS’s alcohol-specific mortality rates for both males and females are at their lowest for 5 years, however they remain significantly higher than nationally and are the in the top 5 among the core cities.

Deprivation.

Harmful drinking of alcohol is closely associated with deprivation and females of child bearing age in the most deprived wards of the city are more likely to die from an alcohol specific condition. (data withheld to protect confidentiality).

Maternal alcohol use and suspected damage to foetus in Rosetown.

From April 2010 to February 2013 in Rosetown there were 11 admissions to hospital using the following Health related groups:

035.4 – suspected damage to the foetus related to alcohol
P04.3 – foetus and newborn affected by maternal alcohol use
Q86.0 – foetal alcohol syndrome

As suggested above, these figures cannot be relied upon due to under reporting. In the UK, there are currently no reliable prevalence figures for FAS or FASD as they are not routinely collected or recorded by the British Paediatric Surveillance Unit (BMA, 2007). However, there is general consensus arising from separate research studies carried out in different countries that the figure for FAS is 1 in 1,000 with FASD being 3 to 4 times higher.
Assuming 1 in 500 babies are born with FAS per year, this would equate to 11 babies in Rosetown p.a.

Numbers of Women Who Report Any Alcohol Consumption at Antenatal Booking.

The crude figures below show data obtained from Rosetown Maternity Hospital who had reported any level of alcohol consumption and had gone on to have a live birth. The crude figures suggest that numbers of women reporting alcohol consumption has actually decreased. See table 17 below. However, these figures do not take into account any changes in the numbers of women having their babies at the Trust.

<table>
<thead>
<tr>
<th>Year</th>
<th>No. of women</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>1606</td>
</tr>
<tr>
<td>2004</td>
<td>1960</td>
</tr>
<tr>
<td>2005</td>
<td>1742</td>
</tr>
<tr>
<td>2006</td>
<td>1444</td>
</tr>
<tr>
<td>2007</td>
<td>1121</td>
</tr>
<tr>
<td>2008</td>
<td>736</td>
</tr>
<tr>
<td>2009</td>
<td>713</td>
</tr>
<tr>
<td>2010</td>
<td>498</td>
</tr>
<tr>
<td>2011</td>
<td>336</td>
</tr>
<tr>
<td>2012</td>
<td>373</td>
</tr>
</tbody>
</table>

Table 17: The numbers of women who report drinking during pregnancy who went on to give live birth between the years of 2003 - 2012
Appendix 11. The results of the 2nd Delphi vote – perceived importance

Figure 13: Importance of Delphi statements compared between first (n=34) and second (n=10) Delphi round.
Appendix 12. The results of the 2nd Delphi vote – scores

Figure 14: BARS ratings compared between first (n=34) and second (n=10) Delphi round.
Appendix 13: The vignette used to illustrate wicked issues in the use of evidence in Thistletown

**National Interactive Seminar: Research use in public health, planning and commissioning for reducing alcohol related harm**

**National workshop 5th November 2013**

**Teeside University, Darlington Campus, DL1 1JW**

**Scottish Case study site vignette** and discussion focussed upon two questions:

- What do we mean by public health?
- How do we deal with issues that occur when public health ‘evidence’ is not completely representative and can be interpreted to provide conflicting findings - what impact can this have?

The presentation consisted of 2 slides, each of which provided a visual representation of the question posed, however findings from the Scottish Case Study site were used within the presentation to explore and debate these issues.

**Slide 1 focussed upon the nature and role of public health**

Public health evidence is only one piece within a jigsaw puzzle of contentious issues taken into consideration by Local Authorities in relation to (on and off-sale) alcohol licensing issues. Within this decision making process debates occur around several agendas including regeneration, employment, crime and safety and social inclusion.

Within this there exists a dilemma around the very nature of public health. Can it not be said that investment into and positive regeneration of an area along with the provision of jobs and accessible healthy food stuffs that a retail development, restaurant or hotel can provide for example will improve public health, positively addressing the wider determinants of health and inequalities?

If this is so, what issues should be taken into consideration regarding any increase in alcohol provision that such regeneration and development may bring. How and where does **this specific single development** fit within existing contexts of overprovision, accessibility, affordability, acceptability, normalisation, alcohol related harms and informed choice? All pertinent issues because, from the perspectives of the developing organisations, the sale of alcohol may be intrinsic to the development, their least negotiable element.

**Slide 2 focussed upon the ‘fit and non-fit’ of public health evidence and potential impact of this**

Alcohol licensing decision making is focussed at the level of single specific premises and the impact that that licence (new or modification) and that specific premise are likely to have. Public health evidence and data however can often be (itself or drawn from) population level epidemiological data which may have a (sometimes considerable) timelag from collection to publication. This can have an impact upon
the credence that is afforded to this data by key stakeholders within licensing. Within qualitative interviews in the Scottish Case Study site interviewees highlighted occasions where alcohol providers and legal agents were keen to source and maximise utilisation of incidences where public health evidence could be seen to be open to interpretation, out-of-date or providing conflicting findings. An example highlighted was the use of data surrounding one geographical area where alcohol provision was non-existent - very low, yet the available data around alcohol related harms for the same area was high. Such anomalies were thought to influence not only licence applications within that specific area but also to discredit the use of similar evidence in other applications elsewhere; if such data states this for this area how can such data be seen to be reliable or credible for other areas or applications. What (if anything) needs to be done to improve the collection and application of public health evidence in alcohol licensing?

The curious tale of ......

The empty city centre buildings & Urban wastelands ripe for picking
The curious tale of .........

The ‘dry’ area & The evidence ?????
Appendix 14: The vignette used to illustrate wicked issues in the use of evidence in Rosetown

National Interactive Seminar: Research use in public health, planning and commissioning for reducing alcohol related harm

National workshop 5th November 2013
Teeside University, Darlington Campus, DL1 1JW

English Case study site vignette and discussion on evidence use at the frontline to address alcohol use in pregnancy

Quotes from the interviews in the English case study site were used to highlight the following dilemmas and generate discussion;

Midwives, GPs and other NHS practitioners face challenges advising women in the context of contested and contradictory evidence about alcohol use in pregnancy. How do public health practitioners and commissioners make sense of it when faced with different sources of evidence and ideas about what’s best for women?

There are gaps in our understanding and intelligence, with limited reliable local or national data available about women, alcohol and pregnancy, and problems of reporting and recording.

The scale of the problem is uncertain, and limited data is available about Foetal Alcohol Spectrum Disorder, with problems of identification and diagnosis.

Pregnant women may be reluctant to disclose their alcohol use because of taboo, stigma and guilt, and a desire to be seen to be a good parent, avoid social disapproval.

Midwives face challenges raising tricky issues with women during pregnancy, amidst time constraints and concerns to maintain contact and build relationships, and not put women off accessing future appointments.

Difficult issues are raised at antenatal booking (e.g. about smoking, substance use, domestic violence), and some data recorded, but not always in ways that capture useful information about alcohol use. For example, there is no standard definition of ‘occasional use’ leaving it open to interpretation. Questions do not take account of timing, frequency or precise quantities.

There is limited understanding of units, and how much is ‘safe’ to drink in pregnancy.

The way questions are asked may be informed by midwives own personal views about alcohol, and its acceptability in pregnancy.

Professional guidelines vary, and professional advice is not consistent.
There is recognition of the need for consistent messages, and some support for a 'zero tolerance approach' advocating no drinking in pregnancy, but health professionals and commissioners are concerned about raising women’s anxiety, when evidence is not clear cut.
Appendix 15: The vignettes used to illustrate the wicked issue when local knowledge managers try to use research evidence (both sites)

Fuse Quarterly Research Meeting: Using public health research evidence - how difficult can it be?

National Interactive Workshop 5th November 23rd January 2013
Teesside University, Darlington Campus, DL1 1JW

The Research Utilisation interviews vignette and discussion focussed upon three questions:

- What is not done with existing evidence?
- Which evidence is preferenced?
- How to make national evidence fit locally?

Quotes from the interviews were used to highlight the curious case of (inter)national evidence being ignored and generate discussion (see slides).

In both case studies, we found that some types of evidence were ignored. For instance, in the Scottish case study site a large body of (inter)national research on the link between outlet density and alcohol-related crime and harm was not used in the decision making process.

Decision makers found it difficult to relate national data from elsewhere to their context and therefore found this evidence less useful in deciding what to do about their problems.

To solve this mismatch a similar process seemed to occur (although for different reasons) in both case study sites: evidence from a range of sources was made fit for local commissioning purposes.

To achieve this, similar mechanisms of localising and tailoring evidence were applied in both case study sites. In the English case study site, localising of evidence occurred with the framework of an annual Joint Strategic Needs Assessment. In the Scottish case study site, this localisation process occurred within an overprovision subgroup of the Licensing Forum.

The localised evidence was tailored in the case study sites by apply marketing research techniques that enabled decision makers to select targeted interventions. In the English case study site, social marketing campaigns were used design and develop local public health interventions. In the Scottish case study site, large volumes of local crime data were projected onto detailed geographical maps that instantly identified hotspots for alcohol-related crimes that could be targeted by the local Crime and Safety Partnership.
Data in easy accessible format with actionable messages were preferred by decision makers. In both sites, face-to-face-presentations were made to relevant stakeholders to explain the findings and discuss its usefulness.

**The curious case of (inter)national evidence being ignored**

Localising and tailoring evidence

“If you’re a councillor, you don’t have time to read a 20-30 page report. You want the headline”.

“We bring a real time understanding, a lot of it is very practical”.

“Policy makers will continue to make decisions based on anecdotal evidence, if we can’t as analysts bring that to life”.

“Locally relevant and internationally recognised data in a local context is the Holy Grail of public health”.

“Just make it simple: what works and feed that back into the operational and strategic environments, so resources can be better targeted”.