

Soft methods, hard targets: Regional Alcohol Managers as a policy network

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Introduction

The Alcohol Improvement Programme (AIP) was a three-year, multi-faceted UK Department of Health (DH) initiative developed to contribute to the reduction of alcohol-related harm, as measured principally by a reduction in the rate of increase in alcohol-related hospital admissions (ARHAs) in England. A key component of the AIP was the appointment between November 2008 and September 2009, of a Regional Alcohol Manager (RAM) in each of nine English health regions. This article draws on a commissioned evaluation of the RAM function undertaken over a 12-month period over 2010-11, to explore how this new role developed and how it fits within wider understandings of 'policy networks' and 'governing at a distance'.

Policy networks and policy implementation

Theoretical perspectives on the way in which centrally-determined policy is implemented (or otherwise) at the local level have developed considerably since Pressman and Wildavsky's (1973) seminal work, *Implementation* (although some commentators have suggested earlier roots: Saetren, 2005). Much of the literature of the 1980s and 1990s can be characterised as a debate between 'top-down' perspectives, whereby policy implementation is seen as a unidirectional chain from central policy-makers, who formulate policy, to local implementers whose responsibility is to implement the policy (e.g. Pressman and Wildavsky, 1973); and 'bottom-up' perspectives which focus on the way in which policy is effectively created through the myriad decisions made by 'street-level bureaucrats' (Lipsky, 1980). Subsequent writers have offered analyses that have attempted to draw on both perspectives (e.g. Sabatier, 1986; Palumbo and Calistra, 1990).

However, a different approach has increasingly taken centre stage in thinking about how policy is developed and implemented: the

idea of 'policy networks'. Underlying this perspective is the recognition that there has been a major change in how policy is managed and delivered, such that networks have become 'the engine-room of the modern British polity' (Hudson and Lowe, 2004). As Kilijn and Koppenjan put it, 'the nature of tasks that governments in contemporary complex societies are confronted with will not allow for command and control reactions. Because of the ambiguity and complexity of these tasks, governments will have to learn to enter into partnerships with other parties' (Kilijn and Koppenjan, 2000, p.154-5). From this viewpoint, policy making and implementation occur in networks consisting of a range of independent actors, with the success or failure of the policy process dependent on the extent of co-operation between these actors. In this context, O'Toole *et al.* (1997) have referred to 'implementation networks' to describe networks of interdependent actors 'involved in the translation of the policy intentions of the national political community into appropriate measures or actions for the realisations of these objectives at the "level of the consumer"' (p.139). While clearly a challenge to the traditional 'top-down' view of central policy enactment, such an approach does not render obsolete the role of Government. Kickert and colleagues have described how network management operates as a 'weak' form of steering 'which tries to influence the strategic actions of other actors' (Kickert *et al.*, 1997, p.167). Governments can therefore engage in different types of network management, such as *network constitution*, involving the introduction of new actors into a network (Kilijn and Koppenjan, 2000).

A parallel literature has focused more broadly on governance – and, in particular the governance of the NHS. Here, commentators have described the shift away from a hierarchical 'command and control' approach towards the use of data, targets, networks and markets in order to 'govern at a distance' (Rose and Miller, 1992; Huges and Griffiths, 1999; Smith, Anell, Busse, Crivelli, Healy, Lindahl, Westert and Kene, 2012). In their comparative study of health systems operating in seven different countries, Smith *et al.* describe how 'In a typically complex health system no one actor has all the knowledge and power required to get things done and the state must therefore necessarily engage in networked governance across many organisations' (Smith *et al.*, 2012, p.38).

The idea of 'governing at a distance' stems from an influential paper by Rose and Miller (1992). Drawing on Foucault's concept of

'governmentality', (Foucault, 1991), Rose and Miller employ the phrase 'technologies of government' to refer to 'strategies, techniques and procedures through which different forces seek to render programmes operable and by means of which a multitude of connections are established between the aspirations of authorities and the activities of individuals' (Rose and Miller, 1992, p.183). One such technology, central to the nation-state since the 19th century, has been the collection and use of statistics, which Rose and Miller see as an active process, 'a way of acting upon the real...in such a way as to make the domain in question susceptible to evaluation, calculation and intervention' (1992, p.185). The collection of data allows governments to define social problems and gives legitimacy to policies and programmes designed to address these problems. Such data collection can also lead to 'action at a distance', whereby local agencies (for example hospitals), can 'work out "where they are"', calibrate themselves in relation to "where they should be" and devise ways of getting from one state to the other' (Rose and Miller, 1992, p.187).

As Greenaway, Salter and Hart (2007) have pointed out, 'much of the literature on policy networks has been theoretically top-heavy', with a lack of detailed case studies (see also Hudson and Lowe, 2004). This article aims to explain the structure, role and impact of the RAMs within the conceptual frameworks of policy networks and government at a distance. In particular it addresses the following questions, which structure this article:

- To what extent did the RAM function come about as a result of the need for the DH to 'govern from a distance'?
- How did the RAMs function as a policy network? What potential was there for the RAMs to act as an implementation network in terms of impact at a local level?
- What was the method and impact of network management by the DH?
- What conclusions can be drawn about the RAMs as a discrete policy network, their relation to other networks and their impact?

Methods

The research reported here is drawn from a wider evaluation of the Alcohol Improvement Programme (Thom *et al.*, 2011). Three main

components of this evaluation have thrown light on the role of the RAMs.

First, in-depth, face-to-face interviews were conducted with each of the nine RAMs, lasting between one and two hours. While a topic guide was used in these interviews, they were relatively unstructured, ensuring a breadth of topic area at this early stage in the research (Fontana and Frey, 1994). Topics covered included RAMs' aims and responsibilities, their programmes of work (including the High Impact Changes, see below), partnership, effectiveness and impact. Meetings of all the RAMs, held in the DH in London were also attended and contributed to the research team's understanding of the links between central policy-makers and the RAMs.

Second, 31 semi-structured interviews were undertaken with regional and local policy contacts identified by the RAMs. These interviews were briefer, more structured and mostly undertaken by telephone. Topics covered included the local policy context, contact with RAMs, High Impact Changes, commissioning decisions, impact and legacy.

Third, six, in-depth face-to-face interviews were undertaken with national-level policy-makers. The focus of these interviews was on the wider policy context, the background and development of the AIP, including the RAM role, and the programme's potential impact and legacy.

Analysis focused on the deductively-derived themes covered in the topic guides but also more inductively-derived themes, which grow out of the fieldwork and analysis (Huberman and Miles, 1994).

The development of the RAM function: Government from a distance?

The past 20 years has witnessed an exponential rise in public concern about alcohol and policy responses to such concern across the countries of the UK (Baggott, 2010; Lloyd, 2010). While much of this disquiet has focused on 'binge drinking' and public disorder, another contributor to public concern has been the dramatic rise in alcohol-related hospital admissions (e.g. Mayor, 2010). Policy responses have been numerous. The Alcohol Harm Reduction Strategy for England came out in 2004 (Cabinet Office,

2004) and The Licensing Act 2003 came into effect in the following year (2005). *Safe. Sensible. Social.* was published in 2007 (Department of Health, 2007) and the current, Coalition Government's strategy in March 2012. Another important Labour Government policy that has driven national and local policy agendas alike over this period was the introduction of a Public Service Agreement (PSA) on alcohol and drugs in 2007: PSA 25 (HM Treasury). Public Service Agreements represented the prioritised aims and objectives of UK government departments for a three-year period, each including its own targets and delivery plan.

The new PSA on alcohol presented the DH with a pressing need to ensure that it could deliver on the associated 'Indicator 2': the number of alcohol-related hospital admissions (ARHAs). However, as was clear from interviews with policy-makers, there was limited potential for the DH to directly influence the work undertaken on the ground by the Primary Care Trusts (PCTs), responsible for managing the provision of primary care in England:

Now as part of the PSA we have to develop a delivery plan...with that comes a load of challenges...throughout all of this the Department's relationship with the NHS is a lot more hands off...But at the end of the day, it's the PCTs who make the decisions about what's in place [DH policy-maker].

..we knew from the centre we couldn't deal with 152 PCTs [DH policy-maker].

A range of indirect approaches was therefore developed, making up the Alcohol Improvement Programme (AIP):

- The Alcohol Learning Centre (ALC) is an online site, providing up to date information on alcohol, training packages, forums for communication and discussion between groups working on alcohol.
- Seven high impact changes (HICs) were chosen as the most effective, evidence-based actions likely to contribute to reducing alcohol-related harm. The first three HICs were enabling actions intended to facilitate intervention. The remaining four HICs were interventions that could be commissioned and implemented at local level.

- The Alcohol National Support Team (ANST) provided PCTs with an intensive four day 'diagnostic' visit, resulting in a recommended plan of action for implementing the high impact changes.
- Regional Alcohol Managers (RAMs)

The original idea for the RAM role emerged from regular meetings held at the Department of Health with Regional Alcohol Leads. While the existence of such posts in Regional Public Health Departments might suggest that a regional alcohol structure already existed, in practice Regional Alcohol Leads had multiple responsibilities, some able to devote only a small part of their time to alcohol issues. The idea of dedicated, single-issue, regional alcohol posts akin to the Regional Tobacco Policy Managers (Department of Health, 2008) was therefore developed in these meetings between DH policy-makers and the regional leads.

So the programme was developed out of that interaction with the regional leads...the regions recognised that for anything to be done around this there needs to be some sort of dedicated regional coordination, similar to the smoking cessation model... [DH policy-maker].

The impetus for the creation of these new posts clearly came from the Regional Leads themselves:

So it was they who said, look we need, like with tobacco, like with other subjects, we need to have a regional office [DH policy-maker]

A Memorandum of Understanding (MOU) was drawn up between the DH and Regional Directors of Public Health outlining the RAM function and expectations of it, in terms of making a regional contribution to reducing ARHAs. It is clear from the MOU that the primary *modus operandi* of the RAMs was to be one of working in partnership and influencing others. While the ARHA targets loomed large, the words 'support', 'influence' and 'co-ordinate' appear frequently in the MOU. RAMs were therefore tasked with using 'soft' methods to achieve the 'hard' target of reducing ARHAs.

Reflecting the detached, 'hands-off' nature of the DH's influence, there were limitations on the degree to which the RAM role could be specified:

...we could dictate to the regions the functions that we wanted to be done but we had to leave it to them as to how they wanted to carry out those functions [DH policy-maker].

Consequently while most of the nine RAMs were based in regional Government Offices, managed by senior public health managers, there was considerable variability in the staffing and working environments associated with the role. Some RAMs worked alone with no additional staff, while others worked in teams of colleagues funded by the AIP. Some were largely peripatetic, spending a lot of time visiting local PCTs: others much more office-based.

Thus the development of the RAM role came about as a consequence of the recognition of the gulf that lay between DH policy and local action, at a time when local action was needed to deliver on a national target. The DH had to adopt 'government from a distance': in the absence of simple, direct levers of power, policy-makers were forced to identify a number of indirect ways of ensuring that the hard target of reducing ARHAs would be achieved. A consequence of this indirect, 'hands-off' approach was the considerable variety in the nature, location and structure of the RAM function across the nine regions.

Another feature of this 'government from a distance', was the construction of local ARHAs targets as a technology of government. One of the policy-makers described the importance of these data:

...so work was put in with the North West PHO [Public Health Observatory] in developing and refining the local alcohol profiles for England. So that produced for each PCT a set of indicators on which they could judge how they were doing...[later] So the information was given to PCTs, well the PCTs then came back...and said 'what can we do about that? What can we do?' [DH policy-maker].

The construction of these local data therefore appear to have constituted 'action at a distance' (Rose and Miller, 1992), allowing PCTs to establish how they were performing on ARHAs in

comparison to others and pushing some of them in the direction of devising plans for interventions.

The HICs also appeared to operate as an effective technology of government.

...it's kind of provided [PCT leads] with a framework for what to do, which is brilliant, absolutely brilliant. It provides an evidence base which has been lacking, it provides the structure, the kind of coordinated approach and also I suppose in some sense, it provides people with something to mark themselves against... [RAM].

The HICs provided a common language and structure through which RAMs could communicate with local partners. While not unchallenged, the description of them as 'evidence-based' was also a powerful feature contributing to their local adoption.

The RAMs as a policy network

In order to explore how the RAMs' functioned as a policy network, it is necessary to first sketch out how the RAMs made contacts with local policy networks and sought to influence them, and what were the factors that appeared to influence whether their efforts were successful.

Making contact

The RAMs differed in the degree to which they already had local contacts and networks. Some were already engaged in local alcohol policy and practice work before taking up the RAM role and there was therefore some degree of continuity. However, for others, this was a new job in a new area and, for them, there was an immediate need to go out to the PCTs in their region and meet with PCT alcohol leads, commissioners and other local alcohol policy and practice contacts. These visits were partly about starting the process of forging relationships with individuals who would be vital partners for future work but they were also about starting the process of mapping the services and work that was going on.

Vital here was the process of forging good relationships. As had always been recognised in the development of the RAM function, their *modus operandi* had to be one of persuasion:

...we don't have any actual power in this role...So it is about - it shouldn't be but it is in a way - about personalities, because it is very much about influencing and bringing people together [RAM].

For some RAMs, it was clear that the die was cast at this early stage in terms of the PCTs that they would work with most closely:

I think there are a couple of areas that...haven't welcomed your input as much...I think it's just that they haven't got themselves as organised and they are therefore not as qualified to have these kind of discussions with me. So they sort of think 'oh god we don't want her coming because what the hell are we going to say to her'. [RAM].

RAMs were therefore only able to engage effectively with a proportion of the existing networks in their regions. To some extent, RAMs appeared to 'go with the grain': given limited time and resources, it was natural and, perhaps, inevitable for RAMs to start work with the PCTs and other partners that welcomed their input. For example, in one area pharmacists were already keen to take forward Identification and Brief Advice (IBA)¹ for young women wanting emergency contraception.

Pharmacists bit our arms off because they decided that this is what we wanted to be doing...they were happy to engage with the programme. So they particularly focused on young women coming in for the morning after pill and that is a particularly profound teachable moment...[RAM].

Structural factors

An important factor influencing the RAMs' engagement was the number of Primary Care Trusts (PCTs) in each region, which varied between nine and 34. This carried significant implications for the extent to which RAMs could visit PCTs and forge close working relationships with alcohol leads and other contacts at the local level.

Another influential factor was the already existent level of communication between PCTs on alcohol issues and the degree to which there was a structure to encourage and maintain such

¹Screening and simple, structured advice which raises awareness around harmful drinking patterns and the associated effects,

communication. Where levels of communication were poor, RAMs brought people together to share analysis of problems and discuss possible solutions. Thus in some areas, RAMs were instrumental in bringing local PCT alcohol leads and commissioners together at the regional level to discuss alcohol policy. RAMs were also responsible for developing practitioner networks. For example one of the RAM teams brought together alcohol nurse specialists working in hospitals in the region:

And basically again we looked across the region and the picture was unclear we didn't know how many we had, we didn't know what they were doing, we didn't know what support they had so...we invited all our core specialist nurses to an event...and following that event we've created three sub-regional networks, two are virtual and one meets now on a regular basis [RAM].

The degree to which local and regional infrastructures were already developed was influenced by the regional and local importance attached to alcohol historically. In some areas alcohol had already been a key regional policy concern for some time, with policy-makers referring to the escalation in public concerns about alcohol over the past decade:

We realised about four or five years ago that there was an emerging issue that was growing in its impact on life expectancy...So we've actually been sort of championing the agenda around alcohol for some time...[local policy-maker].

This policy emphasis on alcohol could be related to levels of local need, often reflecting long histories of regional drinking cultures and associated problems, which had led to more sophisticated thinking and responses to the issue. However, at the local level, the level of priority given to alcohol also related to the presence or absence of individuals who had taken a particular interest in alcohol:

...you need both the proven need from a needs assessment and then you need someone with the interest or drive or determination to take it forward. [RAM]

RAMs' backgrounds

RAMs' backgrounds appear, to some degree, to have affected the type of contacts they made and the type of programmes they

developed. People with criminal justice backgrounds tended to have good contacts within the Home Office sections of Government Regional Offices and, at metropolitan and local levels, with Crime and Disorder Reduction Partnerships². In some cases, this led to frustrations with the clear health focus of the AIP and its main target of reducing ARHAs. Indeed, as will be described later, a number of RAMs found it difficult to ignore the pull of local concerns, particularly with regard to young people and with regard to criminal justice issues.

A connecting network

The RAM function was clearly designed to operate in the space between policy-makers in the DH and local policy networks. In this respect, they were simultaneously part of local networks and yet also part of central Government alcohol policy structures. RAMs regularly attended meetings at DH headquarters, where they were appraised of policy developments and where they also had the opportunity to contribute to debates about alcohol policy. RAMs were therefore part of a wider policy formation network as one of the range of influences acting on DH policy-makers. However, they were also embedded in regional and local alcohol policy structures and networks, engaging in local policy discussions and seeking to influence commissioning decisions. They could therefore be seen as acting in some respects as an 'implementation network'.

A policy implementation network?

A number of factors appeared to limit the reach and effectiveness of the RAMs as a policy implementation network. First, there was a limit to what nine small offices could achieve in a maximum of three years across the whole country. Many of the RAMs had to be selective: they could not cover the large number of PCTs within their regions. Moreover, this selectivity was not based solely on need: there was a tendency to 'go with the grain' and work with those partners and networks which welcomed them. Therefore the RAMs could only offer an implementation network of partial coverage. Second, RAMs did not have the power to 'implement' policy or practice. They were neither agents of government nor street-level bureaucrats but something between the two. They had to rely largely on influence and persuasion to try to have an impact on local policy. Lastly, the local networking function on which they relied for their influence was inevitably shaped by the regional and

² Local multi-agency groups set up to tackle crime, drugs and anti-social behaviour, since replaced by Community Safety Partnerships.

local policy contexts in which they worked. At one end, there was a sense of continuity, with RAMs picking up structures and programmes that were already in place but at the other, some RAMs had to start almost from scratch: setting up basic structures, identifying contacts and endeavouring to raise the profile of alcohol at regional and local level.

Network management: the DH Alcohol Policy Team and the RAMs

Relations between the RAMs and the DH Alcohol Policy Team were generally described by interviewees as very good. There was clearly a high level of contact between the RAMs and DH and the policy team was generally described by the RAMs as accessible, responsive to emails and other queries, supportive and knowledgeable. Some RAMs ascribed their accessibility and 'nous' to the fact that some key members of staff responsible for managing the AIP were seconded into their current roles from without the Department of Health:

...they are a good team...they have a good expert knowledge, they know their stuff and that is partly because they have been drawn from people in the field [RAM].

Perhaps partly as a result, the quarterly meetings between RAMs and the DH Policy Team were open and convivial. This was a policy model based on 'two-way traffic' (Kooiman, 1993, p.4), with RAMs contributing to policy discussions. However, as has already been noted, frustrations and disagreements did occur around central and regional/local policy differences, although RAMs saw the problems as resulting from the broader DH agenda, rather than blaming individuals in the DH policy team.

Dissonance between central and local agendas

As regional alcohol workers with some grant money and a brief to work in partnership, RAMs often saw the need for, or were asked to get involved in, work which fell outside their brief. One area that was 'off-bounds' was lobbying on the price and accessibility of alcohol. Some RAMs expressed their frustration with this. However, the most significant area where local priorities seemed to rub up against national policy was children and young people.

The PSA target was limited to adults and RAMs were likewise expected to focus solely on those aged 18 years and over.

Some RAMs explicitly avoided working in these areas:

I've had to be quite careful not to get drawn into agendas that were not part of my work remit... That is not to say that I don't do things with young people... But I can't be putting my work time into their agenda because I have to stick with the adults [RAM].

However for other RAMs and some policy contacts, the DH Policy Team's opposition to work with young people was a source of considerable frustration:

we've had the silly situation in this region of the DH alcohol policy lead telling us that we shouldn't spend any of our alcohol improvement programme funding on young people because they are only looking at alcohol related admissions at age 18 plus. So where do they think the 18 and overs are coming from? [local policy contact].

For many RAMS, there was clearly a conflict between what was expected of them in terms of regional and local partnerships and what was expected of them by the DH. For some, this problem seemed to be aggravated to some extent, by their management situation: answerable to Public Health managers by line management and to the DH for the AIP. On the other side of the coin, the DH Policy Team was responsible for the allocation of DH funds and, as such, had to ensure as far as possible that they were expended on DH policy concerns. This was therefore a dilemma and, perhaps, one that could only have been avoided by a co-funding arrangement for the AIP across government departments.

In general, the connections between the centre and the region were particularly strong in the AIP, with evidence of mutual respect. An important part of this success appears to have been the previous experience of the DH Policy Team, whose specialist knowledge of alcohol issues appeared to lend them a high level of credibility with the RAMs. An interesting feature of this policy case-study was the blurring of professional boundaries. Some trusted RAMs were particularly influential in policy circles and were invited to attend other, higher-level policy meetings within the DH,

although always tending to speak with the authority of local experience. There was also considerable porosity of the divides between the DH policy team and the outside policy world, with members of the policy team coming into the DH from local policy, voluntary sector or consultancy roles; and members of the team moving out into consultancy roles following the end of the programme. This alcohol policy network therefore appeared to span a number of sectoral and professional divides.

Nonetheless, there were also differences in terms of the pressures acting on people, most clearly evidenced by disagreements over the focus of regional and local work. The stress from the DH on ARHAs was less easy to maintain for the RAMs, who felt that they had to take local priorities seriously in order to establish and maintain the relationships which would allow them to influence local policy networks.

The impact of the RAMs

The large majority of interviewees spoke positively about the impact of the RAM teams. The most common impact referred to was the additional capacity that RAMs provided, allowing governance structures and interagency groups to function much better at the regional level and forging closer links with PCTs. Related to the issue of capacity-building, there were also frequent references to the importance of having a person at the regional level with a single focus on alcohol. Before the arrival of the RAMs, the alcohol brief had often been held by someone with multiple public health responsibilities and this inevitably limited the work that could be done. The RAM posts therefore represented a significant increase in time and attention paid to alcohol issues and often appeared to lead to a quite dramatic change in what could be done on alcohol policy and strategy – particularly when very little had been done before. As one respondent put it:

So I'm hoping it will leave a legacy here that yeah we've got organised. We certainly weren't organised [local policy contact].

While there was not universal agreement, most people subscribed to the importance of having a regional capacity on alcohol and the importance of the RAM teams in this regard:

For me personally I think that you need someone in a lead position to be able to coordinate activity and meetings and groups and be

seen as the lead really at a regional level. I think that's important [local policy contact].

Another vital role was the provision of information: RAMs and RAM teams acted as the regional hub or 'focal point' for information on alcohol, local projects, best practice and contacts. They were also seen as important conduits of information on national policy, through their regular contact with DH policy-makers. In a field where policy has been moving very fast, knowledge and insight into central policy thinking was seen as valuable.

With regard to the impact of RAMs on ARHAs, it was impossible to ascribe changes in the rate of ARHAs solely to the efforts of RAMs. This was due to the large number of factors bearing on the ARHA statistics, including drinking rates and variation in data collection (Thom *et al.*, 2012): but also because of the multiplicity of agents acting on local policy and practice. The RAMs' work was delivered through partnership and influence, and carving out their separate impact in a quantitative sense was impossible. Nevertheless, especially where grants were also made available, there were many instances of RAMs playing a central role in introducing HICs both at the regional and local levels. The RAMs were often described as having accelerated or extended the delivery of interventions: in the words of one interviewee it gave 'some oomph' to these initiatives.

Networks built to last?

The AIP was a time-limited initiative and funding ceased in 2011. Interviewees were asked to consider what would happen when the RAMs left their posts. Many saw it likely that alcohol would become, once again, just another responsibility among many borne by local public health officers. It was also seen as likely to involve the grinding to a halt of many of the initiatives that RAMs had instigated and, in some regions, the atrophy of a coherent regional strategic plan. One specific casualty was thought to be the new networks that had been set up or developed by RAMs and which were likely to 'wither on the vine'.

There were also fears about the loss of expertise and close contacts that had been built up at the individual level:

When we lose that function, we lose somebody who has formed a very close relationship with all the primary care trusts, who knows

her stuff, somebody who knows alcohol inside and out, services inside and out, who motivates people...[local policy contact].

There was a widespread frustration with the short-term nature of the initiative. It was suggested that drinking, with its roots deep in our culture, was unlikely to be significantly impacted by a mere three-year initiative.

There was therefore a shared view that what had been gained by the programmes was likely to be lost following the departure of the RAMs. This was thought to be particularly the case given the dramatic changes facing regional and local health policy structures, with the forthcoming abolition of the regional offices and the new public health role to be played by local authorities in the UK (Department of Health, 2012). It seemed likely to such respondents that, given these changes, the networks, strategies and human capital in terms of knowledge and competence would be lost in the general ferment.

Discussion and Conclusions

The experience of the RAMs offers an instructive case-study in the complexities involved in implementing government policy in a contemporary public health context. Central policy imperatives concerning hospital admissions needed to find local expression in terms of effective interventions. However, in this policy context - as in many others - there was little scope for a traditional, top-down model of policy implementation: to use Klijn and Koppenjan's phrase, 'government is actually not the cockpit from which society is governed' (Klijn and Koppenjan, 2000, p.136). Instead, the DH adopted a number of indirect approaches (government at a distance), among them the introduction of the regional network of RAMs. A 'weak' form of policy steerage was therefore employed to target the 'hard outcome' of reducing AHRAs.

The term 'implementation networks' is problematic in the context of the RAMs, mainly because the AIP was not an alcohol policy that could simply be 'implemented'. At the heart of the AIP was the more effective delivery of evidence-based approaches in order to reduce ARHAs (the HICs). This could not be passed as a piece of legislation. Nor was it readily distilled into a single piece of guidance such as that produced by the National Institute of Health

and Clinical Excellence (NICE) which could be disseminated and its implementation inspected. Given structural constraints, and limited time and resources, the decision was made to opt for government at a distance: the creation of a new network of RAMs who were then expected to impact on local decision-making through partnership and persuasion. The RAMs were therefore more of an *influencing* network than an implementing network.

The concept of policy networks and the idea of government at a distance offer fruitful ways to understand the RAMs and the AIP more broadly. Although the initial imperative for policy action was forged at a high-level between the DH and the Treasury in the form of the PSA, the response to this imperative in the form of the set of policies that became the AIP involved a range of influences, including those of local policy-makers. From this stage onward, the policy process bears the hallmarks of a complex, interactive policy network model. The porous nature of the boundaries between this central government department and the wider world of local policy expertise sits well within the network framework. There was no simple policy chain that ran from one clearly defined official to the next - from ministers, through civil servants and NHS managers to coal-face practitioners. This was a complex, dynamic process, involving individuals whose bearings and roles were not necessarily fixed.

In some respects the DH and RAMs could be said to constitute a single policy network: in terms of a degree of structural continuity between the regional and the central policy levels but also in terms of sharing a common mission that could not be realised by one party and a consequent degree of interdependence. However, there was also a clear division between those tasked with the central policy brief to deliver on the PSA and those who had to juggle central policy directives with local priorities, and this resulted in inevitable tensions concerning the work programmes that the RAMs developed. Therefore, in this particular policy context there were actually three overlapping policy networks: the central government policy network, consisting of policy-makers from the DH and other government departments; the regional policy network, consisting mainly of the RAMs (but also other regional policy-makers); and the local policy-networks, consisting of PCT leads, commissioners and others. These networks overlapped in that some individuals had ambiguous statuses or could move between them: some central policy-makers had recently come

from the regional or local network level and moved back after the AIP; some RAMs found themselves at interdepartmental alcohol policy meetings in the heart of the central policy network; and some RAMs were adept at joining local networks – a necessary precursor to influencing local policy decisions. As the ‘network in the middle’, the RAMs had the greatest potential to be pulled in different directions but were also the lynchpins in terms of potential policy impact.

Lastly, the question should be addressed of whether this act of policy network constitution – the institution of the RAMs – was an effective policy approach. As has been argued earlier, it is impossible to carve out the particular impact of the soft influencing skills of the RAMs on the hard outcome of ARHAs. However the qualitative evaluation showed how the creation of a single-issue, regional alcohol post was able to have a pronounced impact on some local policy networks. The short-lived nature of the initiative was clearly a problem, in that the development of new networks and the credibility needed to influence local policy inevitably takes time. Nevertheless the RAMs experiment does seem to show how, at least for a historically much-neglected policy area like alcohol, the creation of middle-tier, regional networks composed of alcohol specialists can impact both on central and local policy networks.

Disclaimer

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