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UNIVERSITY OF SOUTHAMPTON

FACULTY OF HUMAN, SOCIAL AND MATHEMATICAL SCIENCES

Sociology and Social Policy

Community Health Promotion Organisations: Maintaining Autonomy and Sustainability in Turbulent Times

By Magdalena Zasada

Thesis for the degree of Doctor of Philosophy

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ABSTRACT

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Community health promotion organisations have been disregarded in public policy despite being considered effective in addressing some of the psycho-social causes of health inequalities. Previous research has discussed some likely explanations for this; health promotion is a contested field and UK politics have moved away from supporting communities and considering social wellbeing as policy aims. The availability of funding for such organisations has significantly decreased since cuts were made to public finances as a result of the 2008 fiscal crisis and resources are increasingly distributed through a process of competitive commissioning for specific services. This research therefore aims to build a better understanding of how community health promotion organisations were being affected by these changes and to identify the factors that were significant to the organisations' autonomy and sustainability in circumstances of marketisation and austerity.

This thesis employs Pierre Bourdieu's theories of field, habitus and capital to gain new insight into why community health promotion organisations in England are struggling to remain sustainable and to maintain their autonomy. Drawing on ethnographic research in three case study organisations I demonstrate how community organisations can be disadvantaged in relationships with their local stakeholders which are implicitly shaped by class, professional status and institutional frameworks. Furthermore, the research findings challenge the assumption that hybridisation, i.e. taking on ways of working typical of the public and private sector, is a feasible and effective approach to improving community organisations' sustainability and autonomy. I argue that without the backing of more powerful actors, community health promotion organisations do not have the necessary social, cultural and symbolic capital to secure a stable position in their local health field.

Contents

List of tables and figures

Declaration of authorship

I, Magdalena Zasada, declare that this thesis entitled 'Community Health Promotion Organisations: Maintaining Autonomy and Sustainability in Turbulent Times' and the work presented in it are my own and has been generated by me as the result of my own original research.

I confirm that:

This work was done wholly or mainly while in candidature for a research degree at this University;

Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;

Where I have consulted the published work of others, this is always clearly attributed;

Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;

I have acknowledged all main sources of help;

Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;

None of this work has been published before submission.

Signed:

Date:

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Abbreviations

CVS – Council for Voluntary Service

HAZ – Health Action Zones

IMD – Index of Multiple Deprivation

LSOA – Lower Super Output Area

NCVO – National Council for Voluntary Organisations

NDC – New Deal for Communities

NHS – National Health Service

NIHR- National Institute for Health Research

NICE – National Institute for Health and Care Excellence

OECD – Organisation for Economic Cooperation and Development

PCT – Primary Care Trust

SOC – Sense of coherence

TSO – Third Sector Organisation

VCS – Voluntary and community sector

VSO – Voluntary Sector Organisation

WHO – World Health Organisation

Chapter 1

Introducing community organisations delivering health promotion services

This thesis is a study of third sector organisations which apply community-centred approaches to health promotion in England: a field that is, as I will argue below, under-researched and marginalised in policy and practice. This research originated in my interest in public service delivery, particularly investigating whether involving third sector organisations could contribute to improvements in how health services are delivered at a local level. Whilst scoping the available resources on this topic, I read about a charity that ran community health promotion projects and had recently won a national award for the impact their work had on their local community. What accounted for this success I wondered? I also found an abundance of theoretical literature on health promotion and publications evaluating the lottery-funded Healthy Living Centres programme. I learned about the inspiring history of the Pioneer Health Centre, a community centre set up in Peckham in the 1930's to study the factors that support "positive health"[1]. This inspired me to find out more about how health promotion can be delivered in contemporary times to address some of the social issues underpinning health inequalities which were demonstrated by the recent Marmot Review (Marmot, 2010).

In this chapter I will introduce community health promotion organisations, present the rationale behind this research and set out its aims, approach and key findings. I will also provide an overview of the methods used to address the research problem and of the contents of the thesis.

1.1 Community health promotion

Health inequalities are a significant challenge for public policy in England; the independent review on health inequalities in England published by Sir Michael Marmot (2010) demonstrated that the most disadvantaged groups in society are most likely to experience ill health and have shorter life expectancy. The subsequent Public Health White Paper states that '(w)e need a new approach that empowers individuals to make healthy choices and gives communities the tools to address their own, particular needs' (Department of Health 2010: 2).

[1] A more detailed description of this initiative is given in chapter 2.

With increasing pressures on the NHS, there is an obvious need for such long-term preventative work in the most disadvantaged communities.

“Community” has multiple meanings and is often used as a normative term; in this thesis I will use it to describe ‘a group or network of people who share something in common or interact with each other’ (M. Taylor 2003: 34) and have common interests based on, most frequently, place of residence, but also common experiences, economic interests or cultural heritage. Taylor indicates that it is the common interests that lead people to identify with each other and they ‘provide the glue that can turn a community from a simple description to an active agent' (2003: 35). Considering that health is a shared interest in society, communities can therefore be “agents for health”.

Third sector organisations, i.e. those that are not part of the public or private sector, are well placed to be intermediaries between the state and communities (Marmot, 2010). In this study “community health promotion organisations” are defined as organisations which deliver services based on a “community-centred” approach to health and wellbeing. This means that they

- recognise and seek to mobilise assets within communities. These include the skills, knowledge and time of individuals, and the resources of community organisations and groups,
- focus on promoting health and wellbeing in community settings, rather than service settings using non-clinical methods,
- promote equity in health and healthcare by working in partnership with individuals and groups that face barriers to good health,
- seek to increase people’s control over their health and lives,
- use participatory methods to facilitate the active involvement of members of the public (South, 2015: 15).

Community health promotion organisations have distinctive skill sets and ways of working that enable them to support individuals and communities that are considered “hard to reach” by mainstream health services. The organisations participating in this research focused specifically on community development which is characterised by goals related to ‘building communities based on justice, equality and mutual respect’ and ‘changing relationships between ordinary people and people of power so that everyone can have a say regarding issues that affect their lives’ (Gilchrist & Taylor, 2011: 4). It is argued that community level initiatives which support people in making healthier lifestyle choices through improving

confidence and social relationships can be an effective approach to disease prevention (Green & Tones, 2010). This approach to health improvement is well documented, for example NICE guidance (National Institute for Health and Clinical Excellence, 2008) indicates that community engagement can improve health outcomes. Community health promotion could therefore have a significant role in narrowing health inequalities where there is greatest need.

These sources suggested that small community organisations could be valuable partners for the NHS and local authorities in improving health in disadvantaged communities. However, I was surprised to discover how few of these organisations I could identify in England and that their work remained largely "under the radar", disregarded by policymakers. There was also a dearth of resources about the practical aspects of health promotion, particularly in the community setting. Researchers at Leeds Beckett University have carried out a large NIHR-funded study on volunteering and community participation in public health initiatives (South et al., 2010), but there is no contemporary academic work relating to the organisational aspects of health promotion outside of public sector provision. As argued by Wills et al. (2008) the marginalisation of health promotion is difficult to prove with little research on organisations providing health promotion to evidence it – which in itself an indication of its marginal status. Wills and Douglas conclude that there is a 'surprising lack of national investment in health promotion' (2008: 433) and building the organisational infrastructure to support it is not a national priority. There are undoubtedly many reasons why this is the case and several stand out as particularly relevant to this research.

Firstly, health and health promotion are contested terms; therefore there is likely to be a discursive conflict between those taking a community-centred approach which focuses on facilitating wellbeing and other stakeholders in the health field. Following on from this, there are claims of health promotion being monopolised by health professionals, who struggle to accept lay health workers as potentially valuable contributors to improved health and wellbeing (South, 2015). This is coupled with the often unworkable requirements of providing measurable evidence of effectiveness of health interventions, which can be difficult to obtain for community health promotion organisations. Finally, Conservative government policy, as demonstrated by the Big Society agenda, assumed that civic engagement and community action would spontaneously fill the gaps left after the withdrawal of public services, lacking recognition that such initiatives in disadvantaged neighbourhoods require institutional support. These issues will be discussed in more depth later in this thesis and my research

findings will provide further insights into the processes leading to the marginalisation of community health promotion organisations in their local health fields.

1.2 Research aims and questions

The study commenced with two broad aims. Firstly, I aimed to examine the role community organisations played in their local health system – the quality of their relationships with other actors and their positioning amongst them. It has been acknowledged that reducing health inequalities requires a whole-system approach, where partnerships between statutory bodies and third sector organisations enabled 'a shift in power and resources towards local communities' (Marmot, 2010: 151). Claims made about the "empowering potential" of community-based health schemes need further verification (Bridgen, 2004) and I was interested to find out whether the organisations' supposed role of intermediaries between state agencies and communities brought about the ability to influence local policy decisions.

Secondly, I aimed to identify the factors that allow community health promotion organisations to thrive and deliver services that are recognised to be effective in improving health and wellbeing. The scope of existing research relating to smaller third sector organisations was limited, and focused primarily on "what works", not "what makes them work". Organisational beliefs and practices which underpin service delivery remain concealed in a "black box", and it is argued, 'you cannot know why something works unless you unpick all the factors and processes which underpin it.' (Westall, 2009: 2). It has been recognised that this is an area still lacking appropriate recognition and systematic description:

> 'Third sector organisations are often valued by both the commissioners and the users of public services because of the distinctive approaches and values they bring to the provision of services. However, little research has been done to identify these approaches or to quantify these values.' (Alcock, 2010b: 44)

I would therefore study well-established community health promotion organisations to open the organisational "black box" – identify what works well and how other similar organisations can be best supported to achieve their full potential. I recognised that the unfavourable political and economic climate would be significant for the studied organisations, the years 2010 to 2012 were a period of particular disruption to public services, however I made no assumptions about how and to what extent these would be affecting them. Having limited prior knowledge of these organisations and the issues that would be significant in their work, I commenced fieldwork with four broad questions:

1. How do the organisations work to achieve their goals?
2. What is working well?
3. What challenges do they face in delivering services?
4. What is their role in the local health system and how is this supported by external relationships?

I intended to narrow these questions down after familiarising myself with two organisations during my first stage of fieldwork.

When I commenced fieldwork it became clear that managing the challenges associated with circumstances of austerity and marketisation was the key concern in the organisations. Financial austerity had significantly decreased the amount of money available to local government and NHS bodies and health promotion in the community was not a statutory service, therefore at high risk of not being funded. The organisations' funding was increasingly distributed through a process of competitive commissioning for specific services. This process of marketisation had not only affected the organisations' ability to secure funding, but has also altered the basis of their relationship with local state agencies by 'replacing less formal, often trust-based relationships with formal, contractual relationships.' (Milbourne, 2013: 71). NHS and public health reforms were underway: Clinical Commissioning Groups were introduced to replace PCTs and the responsibility for public health was transferred to local authorities, introducing further uncertainty about future funding streams and collaborative relationships.

These were compelling issues, and previous investigations of how small, community organisations are affected by austerity and competitive contracting has been limited to a handful of studies, such as Hutchinson and Cairns' (2010) study of community anchor organisations, Buckingham's (2011) study of homelessness organisations, Milbourne's (2013) study of organisations providing children and young people's services, and Macmillan et al.'s (2013) longitudinal study which included several local service delivery organisations. Consequently my research focus shifted to understanding how these changes affected community health promotion organisations and how they were managing to continue delivering their services in circumstances of marketisation and austerity.

In the initial stages of research I found that the most significant challenge the organisations were facing was finding ways to remain sustainable whilst continuing to fulfil their mission. Both organisations, to a different extent, were vulnerable to pressures and priorities from external stakeholders which were not aligned with their mission and preferred way of working, therefore experiencing significant tensions between their community development ethos and

the external expectations of how the organisations should operate and what they should deliver. Difficulties relating to autonomy and sustainability are discussed in literature on public service delivery by third sector organisations, however there was an absence of more in-depth analysis of the factors that contribute to organisations maintaining these. Additionally, I discovered that the health field presented particular nuances relating to, for example, professional power and divergent views of health needs and ways of meeting them. The main aim of my further research and analysis was to identify and understand the factors that were significant to the organisations' autonomy and sustainability in a difficult environment.

I was also interested in how the organisations themselves were interpreting and responding to the processes taking place in their policy and institutional environment and found that they were changing organisational practices to meet commissioning requirements and attempting to generate some income through commercial activities. Hybridisation, i.e. the process of organisations incorporating significant characteristics of public and/or private sector organisations into their ways of working (Billis, 2010c), was chosen by the organisations as a coping strategy. It initially presented itself as an effective resolution of the tensions they were experiencing. However, on closer examination of the data collected from the three case study organisations, it became apparent that implementation depended on the organisations having significant human and social resources and came at a cost to the morale of staff, and furthermore, would not in itself guarantee greater organisational resilience. I consequently began to question the political expectation that third sector organisations will take on hybrid identities in response to the marketisation of public services. There has been considerable academic interest in "hybridisation" in the third sector, however the viability of a hybrid organisational model from the point of view of organisational culture and social resources had not been addressed. Contributing new arguments to the debate on hybridisation in the third sector became an additional objective of my research.

This thesis therefore addresses the following three research questions:

1. How are the organisations affected by circumstances of austerity and marketisation of public services?
2. What are the factors that support or hinder them in achieving sustainability and autonomy?
3. Is hybridisation a feasible strategy for third sector organisations providing health promotion services in disadvantaged neighbourhoods?

These are questions that are of particular concern for people involved in community health promotion organisations, but could also be of interest for policymakers and other professionals working to improve population health in disadvantaged areas. The findings of this research will assist in identifying what can be done to provide a more accommodating environment for community health promotion organisations, so that they can remain sustainable whilst maintaining autonomy in determining their aims and ways of working. I believe that this research could also guide future support and capacity-building for community health promotion organisations, re-adjust external expectations relating to their ability to self-sustain and hopefully instigate breaking down the barriers that hinder their work.

Equally, the research findings will be of interest to academics working in the fields of third sector studies, organisational studies and health policy. They will provide new insight into how organisations develop responses to unfavourable political and economic conditions and further understanding of the processes leading to marginalisation of community health promotion. A new perspective will be offered on the hybridisation of third sector organisations which takes into account organisational ways of working and social resources.

1.3 Research methods

Ethnography was chosen as the research methodology to achieve the goal of holistic analysis of the organisations and their context. This allowed me to explore the richness, depth, and complexity of organisational life, capturing the interplay between contextual factors and individual incentives, understanding "ways of being" and relationships. The case study design was particularly useful for in-depth, explanatory description and considering macro, meso and micro level factors. Fieldwork was carried out in three case study organisations over the course of several visits to each location between October 2011 and November 2012 and involved:

- semi-structured interviews with staff, trustees, volunteers, service users and external stakeholders,
- participant observation of the organisations' day-to-day work, both in the office and in the community,
- creative method workshops in two organisations where staff made collages reflecting their organisation's identity (Gauntlett, 2007),
- feedback visits to two of the organisations and discussion of my initial findings with staff and trustees.

Research findings were generated through an inductive process of thematic analysis and Bourdieu's theory of habitus, capital and fields was used as a framework to further analyse and

interpret research results. Investigating three cases gave better insight into the significance of factors which contribute to the organisations' autonomy and sustainability. It allowed for analysis within cases as well as cross-case analysis to identify key similarities and differences between them.

1.4 Key concepts and theories

Sustainability and maintaining autonomy were identified as two significant challenges faced by community health organisations in an austere and marketised environment. Sustainable community organisations are defined here as ones which are able to secure and maintain resources to continue operating in a way that fulfils their aims. "Resources" are understood in a broad sense and include money, people with the appropriate skills, and infrastructure such as access to spaces appropriate for their work. Organisational autonomy is characterised as the ability to remain independent in:

- purpose: setting its values and mission
- voice: campaigning and negotiating – the ability to influence policy and local agendas
- action: designing and delivering activities that meet needs of the communities served, innovate and take risks (Independence Panel, 2011: 22).

In this thesis maintaining organisational autonomy in setting values and ways of working is of particular interest because of the contentious nature of community health promotion. It is often suggested that third sector organisations find themselves compromising on these to access public funding in what is regarded as "mission drift" (Crouch, 2011; Hutchinson & Cairns, 2010; Macmillan, 2010).

Third sector and organisational researchers have largely focused on debating the role of agency (organisations actively shaping their strategies) and structure (external processes pushing or pulling organisations to change) in changes to organisational ways of working (see for example: Acheson, 2014; Buckingham, 2009; DiMaggio & Powell, 1983; Fligstein & McAdam, 2011; Macmillan, 2011). This was acknowledged as an important theoretical starting point for the research, however in the course of inductive data analysis a relational account emerged as the most suitable theoretical approach. Therefore this thesis employs Pierre Bourdieu's theoretical framework which bridges the divide between explanations based on agency or structure and highlights the fundamental interdependence between the studied organisations and other actors in their local institutional context. It provides insight into how the organisations' positioning in the local health system (conceptualised as their "field"), organisational culture (conceptualised as "habitus") and organisational resources

(conceptualised as operational capacity and "capital") interrelate to support or hinder autonomy and sustainability.

This thesis also engages with theoretical discussions of hybridisation i.e. third sector organisations taking on ways of working typical of the public and private sector. Examining the feasibility of a "hybrid habitus" contributes a new approach to considering it as a strategy for community organisations to improve their sustainability and autonomy. I employed Hood's adaptation of Cultural Theory for public management (1998) to capture and conceptualise the different "ways of life" inherent in the organisational cultures of public, private and third sector organisations. This highlighted the inherent contradictions between organisational characteristics required in hybrid organisations.

1.5 Thesis overview and key findings

This thesis continues with a review of literature in chapter 2 which presents the current context of community health promotion and third sector delivery of public services. It highlights the potential strengths of community organisations in improving health in disadvantaged neighbourhoods and discusses some likely explanations for their extremely low profile in public health. It also draws attention to the challenges experienced by third sector organisations delivering public services and possible organisational resilience strategies, including a more detailed discussion of the theory of hybridisation. I introduce Bourdieu's theoretical framework defining his key concepts and explaining how they will be used in the analysis of data. The chapter concludes with the identification of gaps in current knowledge and formulation of the research questions.

Chapter 3 presents the research methodology and a reflective account of some of the experiences and challenges encountered in carrying out fieldwork. It introduces the three case study organisations, describing their background, local and institutional context, resources and provided services.

Chapters 4, 5 and 6 present the research findings which are organised around Bourdieu's concepts of field, habitus and capital. Chapter 4 considers the organisations' institutional context using field theory, describing the relationships and "rules of the game", organisational positioning in their local health fields and strategies for improving them. It sets the scene for developing an understanding of the value of various forms of capital in local health fields. Chapter 5 moves the focus to examining findings relating to organisational culture. The theoretical lens of "habitus" facilitates analysis of predispositions and beliefs which define the organisations' "way of life" and drive their preferred ways of working. These are contrasted

with the expectations inherent in their fields demonstrating the complexity and challenges of trying to reconcile conflicting cultural norms within a "hybrid habitus". Organisational capacity and capital are the focus of chapter 6. Social capital, cultural capital and symbolic capital are discussed as key enablers for improving the organisations' positioning in the local health field, the key determinant of sustainability and autonomy.

Chapter 7 concludes the thesis with an appraisal of its contribution to knowledge and implications for practice and policy. It highlights the limitations of this study and suggests directions of future research.

This thesis demonstrates that austerity and marketisation have impacted on the organisational practices of all three studied organisations. The ways of working of community health promotion organisations were equally determined by individual agency and structural constraints. Organisations were, on one hand, predisposed to adapt, on the other, did not "automatically" adjust their practices to changing circumstances – they resisted changes that were directly conflicted with their values and preferred ways of working. However I found that the ability to strategically respond to threats to organisational sustainability and decreasing autonomy is related to the volume and quality of organisational capacity and capital, therefore organisations are not always able to implement changes. What became clear is that both smaller, volunteer-run organisations and those that are larger and more professionalised have limited means of sustaining their health promotion work in disadvantaged neighbourhoods other than through public funding.

Examining the three cases allowed me to identify some of the factors that support or hinder organisational efforts to remain sustainable and autonomous. The research findings highlight the significant role of contextual factors, such as the institutional environment, support of health professionals and other key players in the local health field and access to a pool of people with adequate social and cultural capital. They also provide a strong indication of the importance of social, cultural and symbolic capital held by the organisations, and individually by their leaders. The empirical evidence presented in this thesis confirms that relationships between community health promotion organisations and public sector organisations are, at best, tenuous and the organisations are disadvantaged in local organisational relationships which are implicitly shaped by class, professional status and institutional frameworks. Therefore without the backing of more powerful actors, community organisations do not have the necessary social, cultural and symbolic capital to secure a stable position in their local health field. Lastly, I established that it should not be assumed that community health

promotion organisations will achieve autonomy and sustainability by taking on ways of working which are managerially-driven and entrepreneurial. Attitudes to organisational hybridity varied significantly in the studied organisations despite facing similar circumstances of withdrawal of support from public agencies and an increasingly competitive funding environment. I found that hybridisation necessitates not only adequate capacity, competencies and skills, but also having particular deep-seated predispositions which cannot simply be "learned" by leaders and staff. It also bears the risk of generating strong tensions within organisational culture which may lead to distortions of organisational identity and undermine autonomy. The research findings have led me to conclude that hybridisation is not a feasible strategy for improving the sustainability and autonomy of community health promotion organisations.

Chapter 2

Between state, market and communities: community health promotion organisations in a changing landscape

Community health promotion organisations, their role in the local health system and the challenges they face operating in the changing landscape of marketisation and austerity are significantly under-researched in the UK. This thesis therefore draws on literature from several fields to explore the variety of issues that influence the sustainability and autonomy of organisations. I begin by discussing policy assumptions made in establishing the aims of public service delivery and defining the role of the state in relation to citizen's welfare and wellbeing. Then I summarise different views on the definition of health and current knowledge about psychosocial determinants of health demonstrating the potential scope of influence of community health improvement interventions. However, as is argued in the following section, the assumptions and practice of community health promotion are marginalised in the public health field, politically contentious and have been discredited through the poor implementation of area-based initiatives of the New Labour period. Considering the characteristics of small third sector organisations as service providers in disadvantaged neighbourhoods demonstrates that they have a particular role in filling the void between state and citizens, however changing relationships between the state and third sector, marketisation and austerity create significant barriers for community organisations. I present concerns relating to the sustainability and autonomy of third sector service providers and some existing insights into organisational strategies for coping with them. There is however a dearth of knowledge about the role and positioning of small organisations in local health systems where funding is directly allocated to disease prevention and public health work. Furthermore, although hybridisation is well theorised as a resilience strategy, current literature does not consider its feasibility and implications for organisational practice in community organisations delivering services in disadvantaged areas. Therefore Bourdieu's concepts of practice, field, capital and habitus are introduced as useful theoretical tools for examining relationships with external stakeholders, organisational resources and preferred ways of working in the context of organisational efforts to adapt to external expectations and to maintain autonomy and sustainability.

2.1 Addressing welfare and wellbeing needs: the policy environment

The aims of public policy are ideologically driven which is noticeable in the rhetoric employed by policy-makers in defining and justifying the role of the state in supporting individual members of society. Economic welfare has always been at the forefront of the debate about the welfare system in Britain; however it is increasingly acknowledged that public policy should also be concerned with wellbeing which focuses on supporting individual capability and highlights the importance of social development, based on personal relationships, trust and participation. Wellbeing reflects the positive aspect of social policy highlighting the importance of generating social value, as opposed to dealing with negative, "social problem" issues (Dean, 2010). Individual wellbeing is achieved when the need for social recognition is fulfilled through intimacy, belonging and respect experienced, respectively, in personal, community and civic relationships (Jordan, 2008). However policies and social institutions often prioritise individual utility over social value (Jordan, 2008; Taylor-Gooby, 2008) focusing, respectively, either on efficiency or on the social aspects of service delivery.

Sustaining the "associative bonds" formed in the domain of civil society has a double significance for promoting health and wellbeing. Firstly, disintegration of social support networks and community institutions has an adverse effect on individuals' confidence and self-reliance with the strongest effect on those already disadvantaged by neighbourhood deprivation. In circumstances of community disadvantage 'self-help and community mobilisation, despite the resource constraints, appear to be one of the few ingredients of a possible upwards cycle' (Power, 1993 in: Billis & Glennerster, 1998: 93); when people are involved in activities with others, they participate in an exchange of social value which can convey respect, solidarity and a sense of purpose fostering individual self-esteem. Secondly, belonging to a group or community enables the social learning processes that equip people with skills and abilities such as autonomy, responsibility and self-control. Grist argues that social institutions sustain such individual qualities through participation and engagement:

> 'families, civic and congregational organisations – are what build associative bonds between citizens. These institutions are the vehicles through which practical knowledge is transmitted, and are essential to producing autonomous and responsible citizens. But they also act as intermediaries, allowing citizens to respond collectively to shared problems. (...) it is local institutions that give people self-confidence and self-respect.' (Grist, 2009: 24)

Grist (2009) therefore suggests an approach to public services which facilitates citizens acquiring the skills needed to participate and take on more responsibility in the public realm. This requires organising them in a way that enables the forming of social relationships and meets a range of wellbeing needs.

Conversely, an ideological shift is visible in the approach to public service delivery in the last four decades of British public policy which has made it increasingly technocratic and less socially orientated. Where previously the welfare state was in a caring relationship with its citizens, Conservative government reforms in the 1980's were propelled by individualism which supports the view that it is the choices and actions of self-motivated individuals that make up social life and collective activity (Jordan, 2006, 2008). At this time New Public Management emerged in many OECD countries as a dominant approach to organising the public sector and has remained influential since. Hood (1991) identified seven key elements of the NPM doctrine as:

- slowing down or reversing government growth in terms of overt public spending and staffing;
- shifting towards privatization and quasi-privatization and away from core government institutions;
- hands-on management with clear accountability and using management tools proven in the private sector;
- explicit standards and measures of performance; decentralisation and disaggregation of organisations;
- competition with term contracts and public tendering and greater discipline in resource use.

Ackroyd (1995) suggests there were two stimuli which led to this change in the welfare system. Firstly, as British society became increasingly consumerist and the public expected choice and service responsiveness, the centralised, ridged and bureaucratised system was increasingly perceived as archaic. Secondly, it was 'the growing cost of the increasingly centralized Welfare State, then, more than any other single factor, which led the Government to take steps to detach itself from the provision of welfare services, and to disassemble the Welfare State.' (Ackroyd, 1995: 25). Consequently the logic of preferences, incentives and contracts was introduced to public policy and I would argue has progressed since with further reforms.

There have been two further political projects implemented in the UK which have been rooted in an ideology that steers direct responsibility for the provision of public services away from

the state and increases reliance on non-state actors. New Labour's "Third Way" was designed in the late 1990's and promoted as an alternative to marketisation policies introduced by the previous Conservative government. The preference for market mechanisms was maintained with increased individual responsibility for making personal choices and improving lives, however policies put greater emphasis on social inclusion and strengthening communities. The voluntary sector was titled a "partner" for public sector organisations in service delivery and users of public services were to take on new identities in the role of partners or customers. However this political project had inherent contradictions. The technocratic approach to welfare services and quality frameworks that focused on targets may have, to some extent, "crowded out" meaningful contributions from the grassroots level. It was criticised for its top-down command and control approach to policy that 'has not fostered social institutions (whether public, private or third sector) that bind citizens together in new forms of solidarity and shared responsibility' (Grist, 2009: 28). Similarly Jordan argues that in fact the proposed means of organising society 'neglect the human dimensions of relatedness – intimacy, the quality of family and friendship relationships, community as convivial association (rather than social control), and citizenship as belonging and solidarity' (2006: 216). Overall, although "Third Way" politics brought about many valuable community-based initiatives (some are referred to further in this chapter), it put public services on a course towards further individualisation, marketisation and regulation of services, creating an unfavourable environment for pursuing social value as a policy goal.

The "Big Society" project was introduced by the Coalition government in 2010 as a counterbalance to the "Big State" created by their New Labour predecessors. Jordan (2011) suggests it is underpinned by the idea of removing 'technocratic formalism' and devolving power and control to citizens through inviting participation and to professionals, by reinstating the value of their judgement and expertise. Political rhetoric presented it as a policy of empowering communities to address local issues through self-organising to deliver local services and 'reconstruction of the fabric of civil society through the associative principle' (Jordan, 2011: 9). It seems as no coincidence that this political programme was launched in a time of economic recession and at the beginning of a course of government austerity measures. The role of the state is presented as promoting and supporting citizens who undertake local collective action, however in practice this was significantly undermined by unprecedented cuts in funding for local government services; there was no budget set aside for implementing support structures for those communities lacking established groups and organisations. Critics are not far from the truth when they claim that the policy was designed

to disguise cuts and transfer responsibility for looking after vulnerable populations to the voluntary sector (Jordan, 2011: 13). Policymakers failed to recognise that civic engagement will not automatically arise as the state withdraws its support:

> 'Ultimately, the Big Society project rests on the assumption that the individuals and families living in places we call 'communities' and 'neighborhoods' have both the capacity and the incentive to act together in those entities; the Big Society sees there being some macro-structures beyond the individual where Thatcher had seen none. And, of course, there are some places in Britain where they do exist. What the Big Society policy omits is any realistic assessment of how these kinds of social structures might be constructed in places where they do not.' (Ware, 2011: 91)

Five years since the Coalition government had come to power the Big Society project has been judged as largely failing to deliver on its promises (Slocock, Hayes, & Harker, 2015). Its fate proves that in periods of economic downturn policy-making becomes ever more focused on managing the increased pressure on the welfare system and improving individual and community wellbeing through the efforts of civil society remains only an empty government slogan.

The current policy approach of placing increased responsibility for wellbeing with society, not government is particularly damaging for disadvantaged communities. Community disadvantage often entails 'the absence of normal institutions of civil society' (Billis & Glennerster, 1998: 92). "Gaps" in the social fabric coincide with areas of disadvantage, so participation and solidarity is more likely to occur in communities which are already better off. There is some evidence that more deprived local areas have fewer third sector organisations (Clifford, 2012) and lower rates of formal civic engagement (Mohan & Bulloch, 2012), therefore a social vacuum is sustained. This may be to some degree compensated by strong informal relationships: 'informal mutual activity is an important source of support in excluded communities' (M. Taylor 2003: 77). However paradoxically, community self-reliance may perpetuate social disadvantage. Studies carried out over the course of the last four decades show that "network poverty" (Perri 1997b: 6 in: M. Taylor 2003: 82) – connections centred largely around one locality and people "like oneself", is a significant disadvantage both in economic terms and through reinforcing unconstructive behavioural patterns (see: Forrest & Kearn 1999; Page 2000; Pahl 1970; Willmott 1986 in: M. Taylor 2003: 82-83). Taylor suggests that 'communities and civil society need to be supported to re-engage people with public life'

and future policies need to address the 'structural factors which reinforce exclusion and the stereotyped approaches of outsiders towards these communities' (M. Taylor 2003: 84) through establishing links with people and institutions outside the localities to turn them into "permeable places" (Forrest and Kearns 1999 in: M. Taylor 2003: 84). However there is little recognition in mainstream politics of the need to promote opportunities for citizens to engage in social organisations which would foster social solidarity. Public services are under pressure to demonstrate effective use of public money, therefore a trade-off is often made between efficiency and social value in public service management. Jordan (2008) asserts that this has led to the "crowding out" of socially valuable inter-personal relationships by marketised services.

The consideration of welfare and wellbeing as policy aims raises questions about the role of the state and relationship between government and citizens. This research takes a particular interest in community organisations that work to improve health and wellbeing in disadvantaged neighbourhoods by addressing psychosocial determinants of health and facilitating the development of community relationships. These organisations see their role as bridging the gap between state and citizens and working alongside public agencies such as the NHS and social care to meet a range of needs, fostering self-confidence, motivation and belonging as a route towards health and wellbeing. Taylor-Gooby argues that 'bottom-up processes to promote social cohesion are not best thought of as substitutes for top-down social interventions and service provision' (2012: 382). Historically this was not a field that public institutions would get involved in, as family and civic structures (such as parishes, workers cooperatives or community associations) would have facilitated community relationships and fulfilled social needs. In modern society the state and market institutions are, to some extent, meeting these needs, however in many localities there is a void in social structures that community organisations aim to fill. Government cannot regulate social engagement or create social capital, however through social policy it can establish social institutions that generate social solidarity, social cohesion and associative bonds within and across communities:

> 'There is a crucial facilitating role for the state, for elected, representative, and dynamic local government agencies, and for politics and ideas in the formation of the kind of balanced social capital required for promotion of population health under the dynamic conditions of continual economic growth.' (Szreter & Woolcock, 2004: 661)

As a result, I argue that policymakers should be particularly interested in supporting organisations and initiatives that are working to bridge the gap between state and citizens.

2.2 Health and health promotion: the psychosocial approach

Health is a complex notion; its meaning is socially constructed and changes with the context and the perception of the person using it (Cameron, Mathers, & Parry, 2008). It is also proven to have different meanings for people of various social class or ethnic groups (Blaxter 1990 in: Senior, 1998). The simplest classification of definitions of health is into negative and positive definitions, and additionally there is the biopsychosocial model which bridges the two approaches. Negative definitions of health suggest 'being free of symptoms of illness' or a 'medically diagnosed condition' whereas positive definitions emphasise 'being physically fit' or 'psychological and social well-being' (Senior, 1998: 5). The most conventional negative definition of health is the biomedical model which focuses on disease and disability. This has been the traditional "scientific" approach developed since the 16th century where 'health and illness are seen as qualitatively different (…) there is no continuity between the two' (Ogden, 2000: 2) with the mind and body functioning independently. This model still dominates medical research focusing on the causes, prevention and cures of disease. Its contemporary supporters highlight that it is established using objective measures, however its limitations in addressing emotional and psychiatric health and considering the social context of health are apparent (Larson, 1999). In the 20th century the perception of the relationship between the body, mind and social environment changed and the biopsychosocial approach to health and illness was developed. The Constitution of the WHO applies this approach stating that 'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.' (World Health Organisation, 1946). The biopsychosocial approach incorporates biological factors, psychological aspects such as beliefs, coping mechanisms and behaviours and social elements such as behavioural norms shaped by class and ethnicity (Engel 1997, 1980 in: Ogden, 2000). It acknowledges that psychological and social factors may contribute to causing or aggravating physical illness, but equally individuals and social groups construct their own understanding and perceptions of health. This "whole person" model sees health and illness as a continuum, not dichotomous categories. The biopsychosocial model of health makes it possible to treat disease but also to focus on prevention and intervention. The positive model of health, also called the salutogenic approach, often refers to "wellbeing", not health as such. Antonovsky's concept of "salutogenisis" (Antonovsky 1979, 1987 in: Davies, 2007) refers to the processes of calling on physical, mental and material resources to generate health, which works in opposition to "pathogenisis" – the mechanisms causing disease. Larson

defines health as 'strength and ability to overcome illness, having a "reserve of health."' (1999: 129), similarly it can be defined as 'the ability to adapt and to self manage' (Huber et al., 2011: 2). It abandons defining health through absolute physical fitness and highlights the positive dimensions of health: 'well-being, energy, ability to work, and efficiency' (Schroeder 1983 in: Larson, 1999: 130). This coincides with how lay people are often found to think about health – as a means to an end, a "resource" that enables everyday engagement in social, economic and political activities (Williamson & Carr, 2009). "Health" is therefore a contentious concept and the multiple understandings of it underlie a large variation of approaches to improving health in society.

There is a wide range of social and psychological factors which have been found to affect health. The social influences on health are illustrated by Whitehead and Dahlgren's (1991) model which presents the interaction between different levels or layers of social factors.

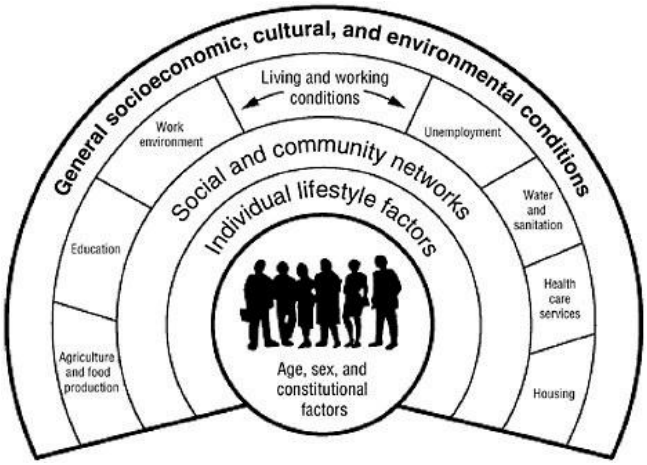


Figure 1: The layered model of health determinants (Whitehead & Dahlgren, 1991)

The lowest level represents personal behaviours and lifestyles of each individual. The second layer is the social and community networks that may have strong influence on individual lifestyle choices through their established norms and values. General living and working conditions are on the next level, contributing a variety of factors such as access to appropriate housing, health services and education, facilities available in their local communities and the supply of goods. These have been found to be strongly related to individual health outcomes and are often referred to as the "wider determinants" of health. Finally the overarching layer refers to the economic, cultural and environmental characteristics of society, which would include, for example, general wealth, health and welfare policies, labour market conditions and generally accepted rules of behaviour.

This model demonstrates that health behaviours are both actor-driven and socially-imposed through culture, institutions and the surrounding environment, however structural factors have the greatest influence on health, as they determine people's income, education and living environment (Marmot, 2010). Marmot and Wilkinson advocate for recognising the powerful psychosocial effects of the socioeconomic structure:

> 'The psychosocial effects of relative deprivation involving control over life, insecurity, anxiety, social isolation, socially hazardous environments, bullying, and depression remain untouched. Evidence shows that these factors influence health and that their prevalence is affected by the socioeconomic structure and by people's position within this.' (Marmot & Wilkinson 2001: 1234)

These two prominent social epidemiologists name three types of evidence for the existence of 'psychosocial pathways associated with relative disadvantage':

- The success of psychosocial variables such as control, anxiety, insecurity, depression, social affiliations in explaining the health gradient
- Studies of the effects of low social status on non-human primates
- Increasing knowledge of the neuroendocrine pathways through which psychosocial factors "get under the skin." (Marmot & Wilkinson 2001: 1233)

People's social experiences and associated psychological mechanisms make a significant contribution to their health outcomes. Social contact, social support, feelings of control and self-worth have a role in sustaining health (Marmot, 2010: 111) and social relationships and engagement have a positive effect on both morbidity and mortality (see for example: F. Bennett, Nazroo, & Popay, 2009; K. M. Bennett, 2002; Golden, Conroy, & Lawlor, 2009; Uchino, 2006). Social contacts and skills are understood to improve individual resilience to the physical and psychological strains presented by the environment through developing their "sense of coherence" (SOC) (Antonovsky, 1987). SOC is a "global orientation" demonstrated by individuals, which shapes coping strategies employed in response to stressors. Its three major components are:

- Comprehensibility – 'the extent to which one perceives the stimuli that confront one (…) as making cognitive sense' (Antonovsky, 1987: 16-17), being able to understand their life

- Manageability – 'the extent to which one perceives that resources are at one's disposal which are adequate to meet the demands that bombard one' (Antonovsky, 1987: 17). It implies that an individual doesn't feel victimised by events or that they are treated unfairly by life.

- Meaningfulness – 'the extent to which one feels that life makes sense emotionally, that at least some of the problems and demands posed by living are worth investing energy in, are worthy of commitment and engagement, are challenges that are "welcome"' (Antonovsky, 1987: 18).

A "sense of coherence" is gained through affirmative experiences of being able to cope with life and managing the potential risks from the environment. It is suggested that the circumstances of one's life such as class position or cultural environment are significant in its development with, for example, those coming from a low social class are more likely to experience chaos, inability to cope and exclusion from socially valued decision making (Antonovsky, 1990: 160).

Health psychology and sociological research confirm that individual lifestyle choices are driven by habit, convenience, socially-constructed needs and wants, and are influenced by individual motivations, self-perception and self-confidence, not solely based on knowledge and rational decision-making (Ogden, 2000; Shove, 2003)**.** The Health Action Model (Tones, 1979, 1981 in: Jackie Green & Tones 2010) identifies two groups of factors which shape health behaviours: those leading to creating a "behavioural intention" and ones that enable or hinder putting this intention into practice. The model's strength lies in demonstrating how individual attributes – beliefs, motivation, norms, personality, knowledge and skills interact with the physical, socio-economic and sociocultural environment in forming behavioural intentions and facilitating their implementation. It is also emphasises the importance of psychological factors relating to a person's capacity for agency such as self-esteem, beliefs about control, and a sense of coherence for responding to health related messages. Ultimately though environmental factors contribute to both phases of the action process and they can 'significantly affect the amount of influence individuals have and their actual level of empowerment' (Jackie Green & Tones 2010: 154).

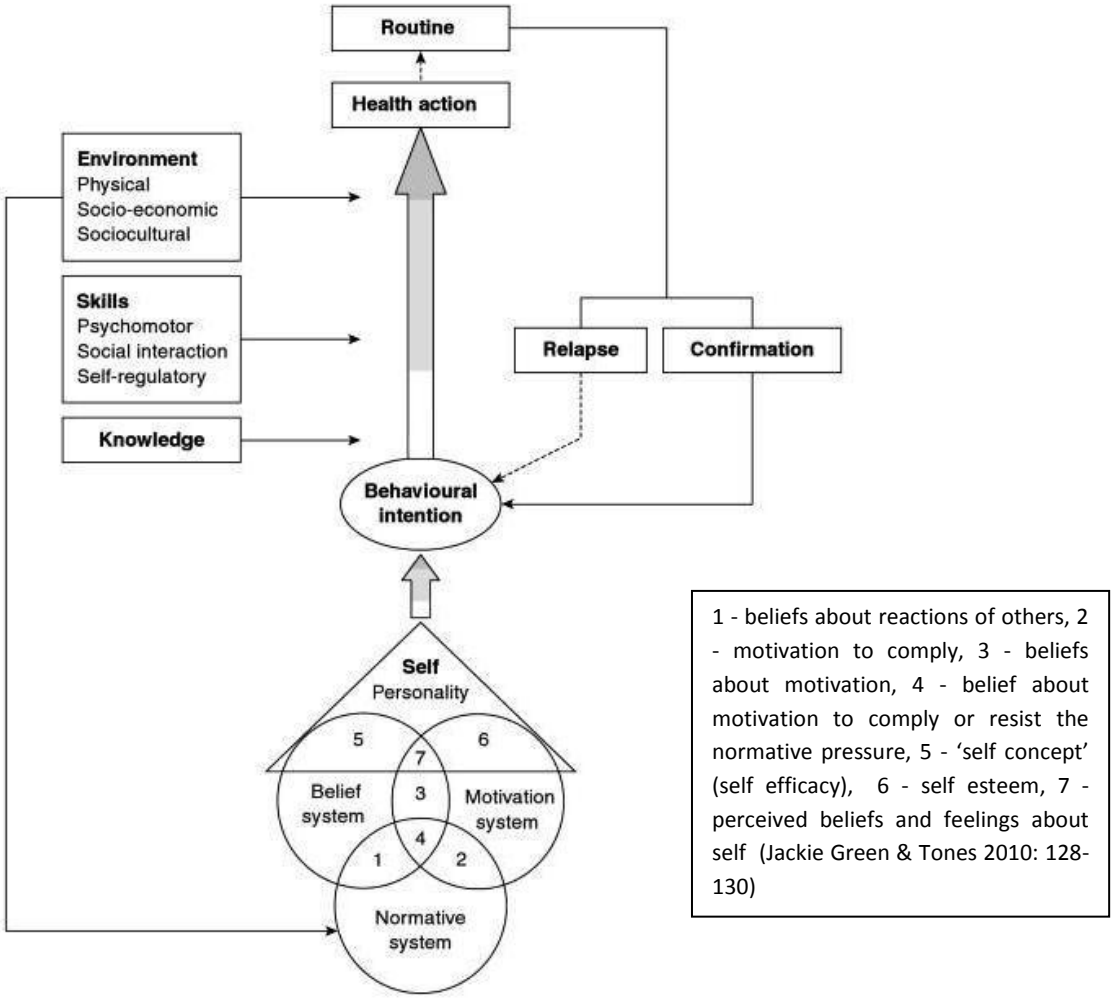


Figure 2: The health action model (Jackie Green & Tones 2010)

Taking a broad and holistic view of health requires considering multiple factors which shape individuals' health and acknowledging that, particularly for those in lower socio-economic groups, there are many "hidden" barriers to healthy lifestyles. It has been found that although the percentage of the population in England displaying unhealthy behaviours (related to smoking, alcohol consumption, diet and exercise) is decreasing, this is largely due to a change in habits of high socio-economic groups with levels remaining stable in lower socio-economic groups[2] (Buck & Frosini, 2012). This indicates that the psychosocial barriers to improving health outcomes in deprived communities are a "hidden" social problem and their significance is largely unrecognised in public health policy.

Effective health improvement in disadvantaged neighbourhoods, where the populations experience multiple deprivation and/or are ethnically diverse, presents specific challenges.

[2] Based on data from Health Survey for England in 2003 and 2008.

Social disadvantage and deteriorating wellbeing can be a self-perpetuating problem due to poverty being 'an experience of feeling powerless to influence the social and economic factors that determine wellbeing' (Dalziel 2007: 108-109). Individual success in the process of behaviour change and implementing healthier lifestyles is particularly influenced by families, peer groups and neighbourhood communities (Gilchrist & Taylor, 2011; Green & Tones, 2010; Grist, 2009). I therefore argue that promoting and protecting health requires interventions which concentrate not only on developing healthcare services and encouraging individuals to make healthier lifestyle choices, but also on supporting them in taking control of their lives and improving their social relationships. Implementing successful and sustainable local solutions to health improvement necessitates taking a holistic approach to health and wellbeing: addressing individual circumstances as well as community-wide issues such as availability of facilities and support, and also, potentially, a change of cultural norms, social perceptions and accepted behaviours.

In the context of persistent health inequalities, policymakers should give increased consideration to health promotion methods which focus not on individuals or on the whole population of a country, but on particular communities. Applying a positive model of health in health promotion which emphasises wellbeing and strengthening personal resilience is 'frequently more effective in achieving preventive outcomes than the more limited tactics employed by espousing a narrow disease prevention model' (Jackie Green & Tones 2010: 13). The organisations which are the subject of this thesis work in and with disadvantaged communities in this spirit to address the "hidden barriers" to health and try to make at least a small difference to the enduring health inequalities in England. I have observed that their role is unrecognised by society and in policy discourse, which I will further illustrate in the following section.

2.3 Community health promotion: a contested field

Organisations which apply a community focus to health promotion operate in a contested field and have been subject to marginalisation by mainstream health actors. Health promotion is most comprehensively defined by the World Health Organisation in the Ottawa Charter as

> 'the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment.' (World Health Organisation, 1986: 1)

This definition does not however remain unchallenged, health promotion's 'scope and nature as a societal commitment, a field of activity, an academic discipline and as a profession has always been contested' (Wills & Douglas, 2008: 431). The first area of tension is applying the negative or positive conceptualisation of health, as discussed above. On one hand, a broad "health enabling" approach is advocated following the direction set out in the Ottawa Charter. On the other hand, the medical model of health education noticeably disregards the wide spectrum of social determinants of health, many of which are beyond direct individual control, contributing to "victim blaming" (Ryan, 1976 in: Jackie Green & Tones 2010: 16). It also overlooks the psycho-social origins of behaviours and lifestyle choices. Both lead to unnecessary "medicalisation" of social issues which can be disempowering, with medical professionals taking on the role of "experts" exercising authority over people's daily lives, taking away their autonomy and confidence, and fundamentally 'undermining self-reliance' (Jackie Green & Tones 2010: 26). Antonovsky (1996) criticized the approach to health promotion which perceives it solely as a programme of disease prevention or lifestyle change. He proposes the salutogenic orientation as a theoretical underpinning for health promotion:

> 'providing a direction and focus, allowing the field to be committed to concern with the entire spectrum of health ease/dis-ease, to focus on salutary rather than risk factors, and always to see the entire person (or collective) rather than the disease (or disease rate) and the collaborator.' (Antonovsky, 1996: 18)

This is suggested to be a new paradigm for health promotion which is particularly salient when public health seems to be refocusing on short-term measures of disease prevention (Lindström & Eriksson, 2006).

The second area of controversy concerns the political implications of the health promotion agenda. The origins of health promotion as a discipline lie in radical social and political movements of the 1980's. This period was characterised by the 'multifaceted and systemic nature of the health promotion movement' (Wills et al., 2008: 527); it was shaped, amongst others, by the rise in popularity of community development and 'the catalyst role of the Health Education Council in establishing health promotion training and units' (Berridge et al. 2006, in: Wills et al., 2008: 527). Community-centred health promotion practice in its radical form had some government financial support from the 1970s to the mid 1990s although it had no political backing. Later the New Labour government presented a rhetorical commitment to health promotion that would support social justice and empowerment, however in reality it applied 'a health discourse imbued with an individualised technocratic version of public

health.' (Wills et al., 2008: 522). Wills et al. suggest that changes and reform of English[3] health promotion organisations have since weakened its position within the public health movement which 'has a narrow epidemiological focus' (2008: 527). At present health promotion is off political agendas and absent from public discourse. Raphael describes the Canadian case, but could well be referring to England when he writes that the "depoliticised" version of health promotion is reduced to 'population health with its emphasis on further research and the application of epidemiological concepts to social issues' and 'the lifestyle discourse of healthy lifestyle choices' (2008: 491). Accordingly, health promotion has been "rebranded" by the UK Faculty of Public Health on its "What is Public Health" website as 'health improvement' (UK Faculty of Public Health, 2010) which is considered a less politically charged term. This has moved health promotion in England far from the empowering agenda of the Ottawa Charter (World Health Organisation, 1986).

Improving health and wellbeing through community-centred initiatives is *not* a new approach contrary to what is declared in the 2010 Public Health White Paper (Department of Health, 2010). Interestingly, the vision of a positive, community-centred health promotion programme predates the Ottawa Charter by over 50 years. The first (probably on an international scale) community centre established with the purpose of promoting healthy lifestyles was the Pioneer Health Centre opened in 1935 in the working class neighbourhood of Peckham in south London. It was an independent initiative of two doctors, George Scott Williamson and Innes Hope Pearse, who set out in 1926 to study the multiple dimensions that combine holistically into health. Their reasoning was unorthodox and ground-breaking, as medical services were concerned predominantly with the study of disease and its cure. They were curious to find out if people would take on greater responsibility for their health and that of their family if provided with favourable circumstances and facilities. Acknowledging the multiple dimensions that combine holistically into health, they sought to create an environment for local families that would promote physical, psychological, social and spiritual wellbeing (Scott-Samuel, 1990). It is believed that community integration together with the creation of social support networks were the most important achievements of the Centre (Scott-Samuel, 1990). The Centre had to close in 1950 despite the great community effort put into reopening it after the Second World War – it had financial problems, but also its principles did not "fit" with the new NHS healthcare model.

[3] Health promotion policy is predominantly in the hands of the devolved administrations of Scotland, Northern Ireland and Wales, therefore this thesis will focus solely on the English context.

In more modern times, “working with communities” became more prevalent as an approach to tackling social problems in areas of disadvantage with the New Labour government proposing to overcome social exclusion through giving people the opportunity to participate in local programmes. The introduction of “area based initiatives” was the first large-scale attempt to get public agencies to acknowledge social vulnerability as a risk factor for disease and the effect of social environments and relationships on health, therefore concentrating not only on improving healthcare services, but also on the social determinants of health. They aimed to facilitate dismantling existing organizational boundaries and forming public sector-led multi-agency partnerships which included NHS organisations, local authorities, the voluntary and business sectors and local communities. One of these initiatives was Health Action Zones (HAZs), twenty-six of which were established in the most deprived areas in England. The HAZs existed between 1998 and 2003 trialling a new collaborative way of working through wide-ranging projects. Two other national initiatives of the New Labour period founded the three case study organisations which are the subject of this research. The first was New Deal for Communities, a government-sponsored programme of neighbourhood-based projects launched in 1998. They were aimed at improving the social circumstances of people living in areas of deprivation, tackling problems relating to unemployment, poor educational attainment, crime and health inequalities. The second was the Healthy Living Centres programme launched by the New Opportunities Fund (subsequently the Big Lottery Fund) in 1999. It awarded grants worth £280 million to 352 projects managed by public sector agencies across the UK, with centres predominantly based in disadvantaged areas. The Healthy Living Centres were set up in association with local government and the NHS, however were not directly accountable to them, which prevented them from encountering some of the problems described below.

Evaluations and commentators, despite being positive about the area-based programmes’ aims and design, have indicated several common shortcomings in their implementation (although understandably, particular cases varied). Firstly, a command-and-control management style was applied in the projects, which was driven by government agencies and focused on implementing national strategies and meeting changing priorities and targets. It was incongruous with the original objectives and in practice it was not possible to fulfil the aspiration of responding to particular local needs of service users and communities (Bauld & Mackenzie, 2007; Hunter, 2007). As argued previously, the New Labour government’s commitment to working with communities was overpowered by its centralised and instrumental approach. Secondly, the ambition of multi-agency collaboration and partnerships

with the third sector was often realised solely on paper. In practice it was found that 'community organisations remain 'junior partners', while powerful agencies determine the rules' (Taylor, 2003; O'Brien, 2006 in: Milbourne, 2009: 280). Thirdly, the programmes often lacked true community leadership and engagement. Researchers evaluating the HAZ programme concluded that overall there is little evidence that the HAZs' strategies were actually shaped by the communities or service users and that they cannot be characterised as a "community-led" initiative (Bauld et al., 2005). Finally, policy-makers lacked the long-term commitment needed for new institutions and practices to become established and community capacity to develop. It was not recognised that community development is a complex and difficult task and therefore the schemes cannot deliver outcomes within short-term timeframe and budget set for the projects (Alcock, 2004; Unwin & Westland, 2000). Subsequently NICE (2008) has issued guidance for providers and commissioners who intend to involve communities in similar programmes. This document highlights the need to understand 'the gradual, incremental and long-term nature of community engagement activities' and to 'set realistic timescales for the involvement of local communities and plan activities within the available funding' (National Institute for Health and Clinical Excellence, 2008: 22). This will no doubt always prove challenging given that it 'is at odds with short political cycles and emphasis put on demonstrating impact in the short term' (Marmot, 2010: 86).

In this section I have explored some of the reasons why community health promotion is absent from policy and uncommon in practice. Future political prospects are unpromising. The fieldwork for this research was carried out in 2011/2012 when the Coalition Public Health White Paper (2010) was still considered an encouraging starting point for policy initiatives that would support community involvement. Changes to national public health structures were implemented, such as introducing local Health and Wellbeing Boards, however there was no government impetus to transform public health practice on the ground. The subject gradually disappeared from public debate and was absent in the campaign before the 2015 General Election (Buck, 2015b). Third sector organisations that seek public funding for community health promotion consequently have been facing several challenges as their organisational aims and ways of working are not aligned with both political priorities and the largely dominant medicalised understanding of disease prevention in the health system.

2.4 Third sector organisations in health promotion: intermediaries between the state and communities

The 2010 Public Health White Paper placed statutory responsibility for public health with national and local government, however it emphasized the key role and value of partnership

between government, the NHS and third sector in helping the most disadvantaged communities improve their health:

> 'Charities, voluntary organisations and community groups already make a vital contribution. They provide services to individuals and communities, act as advocates for excluded groups and catalysts for action.' (Department of Health, 2010: 25).

Supporting people in looking after their wellbeing requires addressing multiple issues which can arise due to factors such as inadequate services from state agencies or social problems exacerbated by mechanisms of social exclusion. Health improvement can be assigned to the remit of many policy areas and support with lifestyle change is often considered to be outside the scope of statutory provision. Implementing comprehensive interventions requires combining a variety of funding streams and collaborating with multiple agencies and this bridging role is highlighted as a particular strength of the third sector:

> 'In a system potentially made up of multiple providers, the voluntary and community sector – with its social and user-centred approach to care – could play a crucial role in co-ordinating care and helping people bridge organisational and professional divides.' (Curry, King, & Mundle, 2011: 10)

There is a particular role for small-scale third sector organisations in addressing the state of community disadvantage - 'the most intractable problem for UK public policy' (Billis and Glennerster 1998: 95). It is argued that disadvantaged communities have lost trust in public institutions which are perceived as 'either not accountable to anyone or accountable only to the rich and powerful' (Narayan et al. 2000: 117 in: M. Taylor 2003: 10). Statutory agencies are also encountering some significant barriers in trying to engage lay people in local initiatives due to their authoritative status:

> 'The legacy of paternalism will not easily be challenged by the newfound commitment to empowerment, especially if this is, in itself, perceived by some as a top-down policy priority.' (Alcock, 2004: 92)

The Marmot Review, a government-commissioned report on addressing health inequalities published in 2010, supported community organisations as intermediaries between state and communities in addressing health needs and recommended that a range of third sector organizations have input into local health strategy, service planning and commissioning and implementation:

> ‘The third sector has a major role to play in developing local engagement and partnerships through establishing and drawing on links with local people, families and communities. The third sector is well placed to access communities and identify assets that would extend community networks, engaging and supporting individuals and developing community infrastructure through self-help, unpaid work and voluntary endeavour.’ (Marmot, 2010: 160)

Organisations in the third sector deliver services to those in greatest need in society who are not able to be “utility maximisers” because they are financially disadvantaged (lack of financial means); personally disadvantaged (unable to exercise choice); societally disadvantaged (burdened with social stigma) or community disadvantaged (resident in a dilapidated area) (Billis & Glennerster, 1998: 87-88). This is in contrast to state and market agencies which provide services ‘used by utility-maximising individuals and can be analysed in terms that are familiar to economists and political scientists’ (Billis & Glennerster, 1998: 87). Billis and Glennerster argue that addressing community disadvantage is facilitated by ‘inherent structural characteristics of organisations’ (1998: 80): localism and small size are key factors as they allow services to be more accessible and responsive and make it possible to develop niche provision meeting the needs of specific groups (Hopkins, 2007). Small community organisations are therefore in a position to play a particular role in health promotion due to being neighbourhood-based and having in-depth understanding of the needs and issues particular to the groups they work with.

Community organisations are necessary in disadvantaged communities to provide stimulus, connections with external agencies and a formal structure for community activity which would otherwise not be possible. South et al. (2011) draw attention to the benefits of recruiting volunteers from the communities targeted by health promotion projects. They demonstrated that involving lay people can “bridge the gap” between communities and public institutions:

> ‘’Reach’ was a key concept, with volunteers reportedly able to connect with a community disengaged from, or resistant to, mainstream services.’ (South et al., 2011: 309)

They could fulfil the role of passing on health messages and ‘build trust in welfare systems’ (South et al. 2011: 311) due to their use of “natural social networks” and lay status gaining access and trust where health professionals are not able to. It was also found that lay

community members made a valuable contribution to the improvement of community health promotion programmes by providing knowledge and insight into community life:

> 'lay experience needs to be incorporated within service design and delivery as such knowledge is distinctive and may even challenge professional expertise' (Popay et al, 1998 in: South et al., 2011)

The overlapping roles in community organisations is claimed to allow for a closer relationship with service users and "stakeholder ambiguity"[4] that can incentivise to 'greater motivation, sensitivity to, and knowledge about client need' (Billis & Glennerster, 1998: 91) in providing human services. The ability to build relationships based on local knowledge and trust is a distinctive advantage of community organisations in health promotion where broad and long-term participation and engagement is crucial for success.

Third sector organisations have many distinctive advantages as service providers, however it is unlikely that they will be able to address the problem of health improvement in disadvantaged areas on their own. Salamon's (1987) theory of "voluntary failure" highlights the inherent weaknesses of the sector: insufficient resources, inequitable distribution, restricted interests and amateurism. Some of these issues have been overcome with public sector commissioning processes and organisations becoming increasingly professionalised, however studies have indicated that there is a "spatial inequality" in the distribution of third sector organisations – the most disadvantaged areas in England have significantly fewer neighbourhood organisations than the most prosperous ones (Mohan, 2012). Those that work in deprived areas are more reliant on government funding (Clifford, 2012) and on professionals to run them as communities lack skilled leaders and project managers (Lindsey, 2013). It is expected that the state, as part of its overall responsibility for welfare, should "compensate" for these shortcomings of the third sector and provide support for existing organisations working in disadvantaged areas and for the establishment of new ones as service providers.

However community organisations providing health promotion services, similarly to other organisations in the third sector, are currently facing challenging changes to their relationship with the state and public sector organisations. Firstly, the requirement of demonstrating the value of community health promotion work is difficult to satisfy on the terms set by potential

[4] 'The key characteristic of the ambiguous voluntary agency is the complexity of overlapping roles. (…) these are not idiosyncratic and temporary aberrations, but a fundamental, structural characteristic resulting from their occupation of both the associational and bureaucratic worlds' (Billis & Glennerster, 1998: 91).

funders; the health service is driven by a medical model of health and there is very little support on a national level for social interventions (Curry et al., 2011). Health commissioning is set up to be evidence-based for treating specific clinical conditions not holistically meeting the needs of individuals (South, White, & Gamsu, 2013), therefore health promotion targets are focused on particular public health priorities, for example helping individuals with weight loss. It therefore may be difficult to persuade health commissioners and GPs to acknowledge the benefits of the community development approach which is at the heart of community health promotion work. Local authorities which have taken on responsibility for public health are seen to be better at engaging with communities, however their budgets have been significantly cut and health promotion services are deemed non-essential.

Secondly, as outlined earlier, there has been a political preference for state retrenchment from welfare provision and direct support for third sector organisations. Public health policy rhetoric which supports community engagement is contradicted by the government established mechanisms for resource distribution (South et al 2013). The current policy of marketisation has been justified by a need for transparency, efficiency and accountability in the commissioning process; grants previously given to community organisations to deliver services are increasingly being replaced with competitive bidding, open on equal terms to organisations from all sectors, followed by signing of detailed contracts (Thompson & Williams, 2014). This has considerably changed the organisations' place in the local health system and the terms of their engagement with public bodies, other local agencies and possibly even service users:

> 'The changes that instilled market forces into public service provision permanently disrupted prevailing cultures of relationships between the VS and the local state, replacing less formal, often trust-based relationships with formal contractual relationships.' (Milbourne, 2013: 71)

Public funders are taking a managerial approach of increased regulation and performance management which has significantly increased the exertion of external power over community organisations:

> 'The growth of widespread service contracts, with associated regulatory controls and risk management has produced asymmetric power relationships, played out through the management of performance outcomes and transfer of risks.' (Milbourne & Cushman, 2013: 490)

As a result, many organisations are losing the flexibility they had in designing their services to best meet the needs of their target groups – often those who do not benefit from mainstream provision in the first place. This can be further exacerbated by the lack of understanding of third sector values and organisational cultures and ineffective management of commissioning processes (Crouch, 2011). Contracting has taken on a bureaucratic "black box" approach with commissioners interested in outcomes and meeting formal criteria (Westall, 2009). As Harris (2010) noted, the organisation of public services has become increasingly focused on efficiency. The "what matters is what works" approach disregards the organisational distinctiveness of how different organisational forms are more or less suitable for delivering social value.

Third sector organisations are well positioned to serve as intermediaries between the state and communities (Marmot, 2010) and to promote health in disadvantaged neighbourhoods due to the opportunities they provide for addressing some of the psychosocial barriers to health. There are however justified concerns about third sector organisations changing their ways of working to meet government expectations and improve their chances of remaining sustainable in a difficult financial climate (Harris, 2010; Milbourne, 2013). There is a risk that they could lose the qualities that are particularly valuable in the services they deliver: their mission, values and voluntary contribution (Billis, 2010a: 10) because of their increasingly challenging relationship with the state. The government aims to present its approach to public service reform as a pragmatic compromise between meeting social needs and dealing with a crisis of public finances. However I would not consider introducing market principles and managerialist practices to be ideologically neutral and it creates a hostile environment for organisations applying a community-centred approach to health promotion. The following section will consider the various trajectories taken by third sector organisations in an endeavour to remain sustainable and autonomous in times of austerity.

2.5 Maintaining autonomy and sustainability: organisational responses to external change

Changes in the policy environment and cuts to public sector funding have had a noticeable effect on many third sector organisations in England; they have lost a significant proportion of their income through reductions in service contracts, grants and donations since 2010 (NCVO, 2013). McKay et al. (2015) studied data from 2002-2007 and have evidenced that the general trend in "average" TSOs in England and Wales is for commercial revenue to become a partial substitute for grants and donations. Nonetheless, the sector is very diverse and is comprised of organisations ranging from several people associating informally to achieve small-scale goals

to national organisations delivering large publically funded contracts. These organisations are therefore influenced very differently and their responses to external change also will vary. Some struggles are however nearly universal in the third sector and sustainability and organisational autonomy are issues that have raised significant concerns. In this section I will discuss these particular challenges and then consider organisational resilience strategies.

Organisational sustainability refers to the organisations' ability to secure and maintain the resources necessary for carrying out organisational activities which fulfil their mission. "Resources" refer to financial means, but are also considered here in a broader sense to include human resources and access to community infrastructure. Although organisational requirements vary, it is acknowledged that even volunteer-run initiatives need some financial resource to provide services in the community (South et al., 2013). Sustainability can be achieved through access to resources from external sources or having the ability to generate them through fundraising or commercial activity. In Billis' (2010c) "ideal model" third sector organisations are characterised by dependence on volunteer labour and, financially, on membership dues, donations and legacies. However health promotion in areas of social disadvantage is, on one hand closely aligned with government priorities and responsibilities, and on the other, is unlikely to be sustained through funds generated locally. Furthermore, community engagement projects take a long time to establish and start having an effect, therefore this type of health promotion intervention needs long-term funding before outcomes can be evaluated (South et al., 2013). There is no uniform experience of commissioning, even for one type of services in a particular geographical area and no "one size fits all" solution. The competencies and approach of particular commissioners and the effectiveness with which the process is implemented by particular public sector bodies are found to be the crucial factors (Crouch, 2011; Rees, Miller, & Buckingham, 2014). Nevertheless, the general experience is that continuity of funding from state sources has become uncertain for community organisations due to changing agendas and priorities (Nevile, 2010) and they therefore often feel pressure to comply with the set terms of contracts and/or seek new sources of financial revenue to have a reliable income.

Organisational autonomy is a position of freedom in three areas: purpose, voice and action (Independence Panel, 2011). Independence of purpose allows organisations to shape their aims to meet changing local needs and to maintain their mission and values. Independence of voice means they can speak up for their cause and be heard without worrying about the consequences. Independence of action is having the freedom to provide services in an

innovative and responsive fashion in accordance with their mission. Billis argues that ideally in third sector organisations 'work is driven neither by the need to make a profit nor by public policies but primarily by the association's own agenda' (2010c: 53). This is particularly crucial for small, community-centred organisations whose work with hard-to-reach groups relies on maintaining relationships of trust with their local community (Harris & Young, 2010). Organisational autonomy does not necessarily imply complete independence from other organisations, it is rather perceived by many in the sector as an *interdependence* between the public, private and third sector that respects the values, mission and purpose of each organisation. In a study done with chief executives of small third sector organisations it was found that interdependence could be beneficial in achieving organisational goals and having an impact:

> 'It was felt that strong, effective relationships, with those in all sectors, were far more important than pursuing organisational independence as some kind of abstract ideal.' (Crouch, 2011: 252-253)

Third sector independence has been an area of concern particularly in relation to the balance of power in the contracting process. Many organisations feel independent in "mind", however target-driven funding and contractual service-level agreements often constrain organisations' activities and their ability to meet need (Knight & Robson, 2007). An enquiry carried out by the Independence Panel (2013) concluded that organisations have three 'sources of power' which support organisational independence: financial power (diversity of income including private income and strong reserves), brand power (having widespread public trust and respect) and knowledge power (well evidenced insight into service users' needs and how they can be met). These assets assist organisations in successfully advocating for their beneficiaries and only accepting contracts that will not compromise their work. Macmillan et al. similarly conclude that 'relative positions and inter-organisational relations' and 'the financial and other resources, or 'forms of capital', as well as internal capabilities required to continue functioning' (2013: 19) determine whether organisations can be relatively unconstrained in how they operate in their local context.

Reconciling sustainability and autonomy can be difficult for community organisations. Knight and Robson state, rather optimistically, that "independence" is 'as much a feature of attitude and behaviour as a set of funding relationships' (2007: 55). Maintaining a strong, stable sense of mission and coherent decision-making protects organisations from unsettling external trends and detrimental compromises and supports their autonomy and sustainability

(Milbourne, 2013). I would argue though that this is not necessarily easy to achieve. On one hand fulfilling their mission requires organisational capital and resources, on the other, organisations are often limited in the funding options available to them, either by their environment or organisational capability, and therefore they have to adjust their work to external agendas to sustain their work. Furthermore, the extent to which organisations can make autonomous decisions in relation to their structures and ways of working is largely determined by how they achieve sustainability and the quality of funding relationships i.e. their reliability and how accommodating commissioners are for third sector organisations. Milbourne and Cushman (2013) indicate that a key tension in the relationship between organisations and their public funders is the necessary trade-off between autonomy, which allows organisations to be responsive to changing conditions and needs of communities, and accountability which ensures that public resources are being spent honestly for the public good. They argue that neither the New Labour nor the subsequent Coalition government have managed this trade-off constructively, with the former being generous but over-controlling, and the latter giving greater autonomy but with significantly reduced financial support.

Organisational resilience, i.e. having the capacity to overcome adverse circumstances, has become a highly debated topic in third sector research with particular interest paid to strategies and associated organisational changes in circumstances of marketisation and managerialism. The term "resilience" is used here with caution, as the responsibility for remaining sustainable should not be placed solely with the organisations and their ability to "cope":

> 'The policy emphasis remains on success through competition, VSOs can survive if they adopt the right strategies; and responsibility for survival is individualised, locating failure as a deficit in individual organisational behaviours, rather than deficient policies, institutions or deep-rooted social or economic problems' (Milbourne, 2013: 157)

Organisations take different approaches to protecting their autonomy and remaining sustainable. I have not identified any previous research on community organisations working in the health promotion field in England, therefore it is necessary to gain insights from other areas of welfare provision and general third sector studies. Changes in the relationship between third sector organisations and the state have been found to result in a change of organisational structures and ways of working to incorporate characteristics of state organisations or businesses (Evers, 2005). "Institutional isomorphism" is the process of

organisations adopting the working practices of others. DiMaggio and Powell (1983) who coined the term identified three types of mechanisms which drive the process: “coercive isomorphism”, when more powerful agencies impose changes, “mimetic isomorphism” which stems from an organisation’s need to reduce uncertainty by copying the practices of others perceived to be successful and “normative isomorphism” when change is motivated by the need to gain legitimacy and recognition from others. Examples of each type can be easily identified in third sector organisations: implementing public sector performance management measures due to contracting requirements, generating income through trade and introducing more structured relationships with service users, respectively.

Isomorphism however is not always an adequate explanation for change in third sector organisations. It focuses on structural processes pushing or pulling organisations to change, therefore disregarding the role of organisational agency (Fligstein & McAdam, 2011). In reality there are organisations that make a conscious choice about engaging/not engaging with external funders and the terms they do this on. In her research Milbourne distinguished three different organisational types amongst small community organisations (providers of children and young people’s services) according to their responses to changing relationships with state funders: resisters, accommodators and entrepreneurs (2013: 158). They are not mutually exclusive categories, rather overlapping types lying on a continuum and do not indicate whether an organisation is better or worse equipped for surviving – the research found examples of organisations that that endured and those that failed to sustain themselves in each category.

Resisters are organisations which aspire to remain independent from state agencies. Buckingham (2010) found that this type of organisation usually would provide informal services on a relatively small scale and would be mostly focused on delivering social support alongside meeting basic welfare needs. The role of small community organisations is often to “fill gaps” with targeted and flexible services which often offer an alternative, more holistic approach to addressing welfare issues and are considered “uneconomic” for public agencies. Their small size and local reach are characteristics which enable them to achieve their aims: ‘Adopting every opportunity for growth, then, is illogical as a survival strategy for small VSOs.’ (Milbourne, 2013: 174). Some organisations therefore resist external pressure to bid for larger contracts, to generate income independently or to concede to commissioning requirements which are at odds with their ethos and mission. Maintaining autonomy is prioritised against securing more funding. However Millbourne’s (2013) study also found that there is a risk that

resisters' reputation may be damaged due to external perceptions of their defensive position and consequently they may lose the confidence of existing public sector partners.

The further two types of organisations are ones where there is a degree of "hybridisation" – taking on ways of working alien to the third sector model (this is further discussed below). Accommodators are organisations which attempt to maintain their community identity, whilst engaging with public sector funders. Buckingham refers to them as "cautious contractors", and highlights the challenging nature of their situation: 'having to reconcile the demands of government contracting with those of volunteers, donors and clients, as well as their own organisational values' (2011: 169). They "professionalise" to some extent to conform to commissioning requirements and to overcome the "amateurish" image of third sector organisations, however this may carry the risk of undermining their community capacity-building role as paid staff replace volunteers (South et al 2013). Their autonomy is largely dependent on the extent they are able to negotiate the terms of their funding to better match their organisational goals and ways of working, however it is observed that 'negotiable spaces are also decreasing' (Milbourne, 2013: 177). These organisations are at risk of "mission drift" if their organisational culture isn't a strong enough to provide a cohesive framework for managing external changes and pressures according to their values and preferred ways of working.

The third organisational type, entrepreneurs, is one where a business-like approach is used to diversify income. They see running a profit-generating arm (e.g. a café) as a way to fund their community activities and therefore as a means of improving the organisation's sustainability and autonomy. Government policy has increased the popularity of entrepreneurial approaches directly, through supporting the establishment of social enterprises and community interest companies, and indirectly, by implementing policies that are driving changes in organisational environments, such as introducing markets to the organisation of public service provision. These changes have introduced greater risk and instability for community organisations prompting them to try to establish a source of income that would be independent of public sector funders, for example setting up trading activity on the open market. It is likely that in most cases organisations embark on such ventures out of necessity, not aspiration:

> 'the present shifts in welfare mixes and hybridization processes are not the outcome of strategic choices but, rather, of coping strategies of actors and organizations under conditions of uncertainty.' (Evers, 2005: 745)

In the current changing landscape of public service delivery and with political rhetoric promoting social enterprise models, maintaining organisational autonomy and sustainability is a significant challenge. Some organisations "drift" towards a hybridised organisational model, others are deliberately changing their ways of working to ones which they perceive will give them a better chance of improving their sustainability and/or autonomy. It seems that there is no answer to the question whether, for example, resistance to change or hybridisation are the "right" course of action for community organisations. More research is needed to understand the implications of organisations taking a particular course of action. The following section will draw on theories of hybridisation to gain better insight into the different aspects and outcomes of the process.

2.6 "Hybridisation" in the third sector

The three "sectors" of the economy: the public sector, the private sector and the voluntary and community sector are differentiated by features such as their purpose, ownership and finance mechanisms. Hybridisation is the process of organisations taking on working practices typical of other sectors as they 'learn to be efficient players in the services marketplace' (Harris, 2010: 33). As evidenced earlier, the traditional boundaries between sectors and their roles in society are becoming less distinct in public service delivery and "hybridisation" is equally a process of political, economic and social change. Many public services are delivered by non-governmental agencies, businesses are engaging with the "social responsibility" agenda and community organisations trade to support themselves financially. Organisations whose core working principles draw from different sectors are now becoming ubiquitous across service areas (becoming prominent even in the NHS which has always embodied UK state welfare principles) and they have become a significant influence in the design of public services in the recent years (Billis, 2010a). The theory of organisational "hybridity" has been developed to capture and explain the complex processes that are not adequately accounted for by theories relating to traditional "sectors" of public life and the organisations that work within them. This section presents current academic theory and knowledge about "hybrid" organisations and the processes leading to hybridisation in the third sector.

The concept of organisational "hybridity" can refer to organisations originating from any of the three sectors which 'possess 'significant' characteristics of more than one sector' (Billis, 2010a: 3) and offers a means of establishing a new identity, which is defined by Evers as 'an unfinished and perhaps to a degree open process' (2005: 742). Brandsen et al propose a broad definition of hybridity: 'heterogeneous arrangements, characterized by mixtures of pure and incongruous origins, (ideal) types, "cultures," "coordination mechanisms," "rationalities," or

"action logics."' (Brandsen, van de Donk, & Putters, 2005: 750). Here I will discuss "hybridity" primarily as a tool to better understand the transformation of third sector organisations and their relationship with other sectors.

There are several theoretical approaches to hybrid organisations in current literature. Brandsen et al. (2005) conceptualise them as a new, separate sector arguing that they are a prevalent and enduring feature of the service delivery landscape. This approach is not however practical for this study as it neglects the third sector organisational origins which are significant to organisational identity. Buckingham (2011) places third sector welfare on the vertex of a "welfare pyramid" alongside state welfare, market welfare, and informal welfare, which create a "tension zone" in the middle described as a "space of hybridity". The inclusion of informal welfare provision in the model highlights the significance of the social integration function which is often taken on by community organisations offering service users social and emotional support alongside core services. However this thesis is considering primarily the organisational aspects of service delivery, therefore including informal service provision in the framework is not particularly useful.

This research draws on Billis' "prime sector approach" which acknowledges organisational "roots" in one of the three sectors distinguished by adhering to 'the principles of accountability inherent in either the public, private or third sector' (Billis, 2010c: 57). He argues that each sector has its "ideal type" organisational form and each works according to distinctive principles in five organisational dimensions: ownership, governance, operational priorities, human resources and other resources. Each sector can have three zones of hybridity, as demonstrated by the figure below, where some of its distinctive principles are replaced by those from one or both of the other sectors.

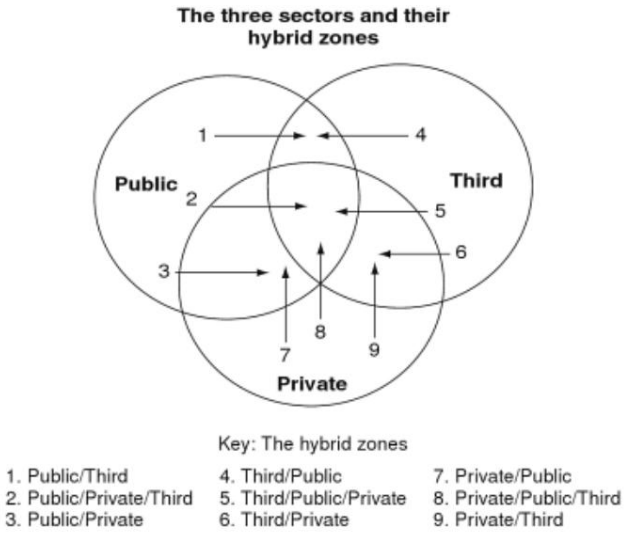


Figure 3: The three sectors and their hybrid zones (Billis 2010c)

Billis (2010c) therefore proposes analysing hybrid third sector organisations through examining their proximity to the third sector "ideal type", the association, which is owned by members, governed by private elections, committed to a distinctive mission, relies on members and volunteers as human resources and is funded by dues, donations and legacies. "Hybridisation" occurs when some of these principles are substituted by those from other sectors: when a third sector organisation commits itself to public service and policy implementation or to being competitive in a market environment, generates income from sales/fees or public money and takes on paid employees. Hybridity also affects the organisational steering mechanisms characteristic of each sector: markets are driven by competition, hierarchy organises bureaucratic state organisations and associational practices are typical of the third sector (Hood, 1998). These come together in hybrid organisations: 'In various sub-sectors of the social services, the steering mechanisms of hierarchy, networks, and markets overlap and intertwine.' (Evers 2005: 741). This dimension is not explicitly mentioned by Billis (2010c), but will be discussed later as it has significant implications for organisational culture.

Billis (2010c) classifies third sector hybrid organisations into two different groups depending on the degree of hybridisation: shallow and entrenched hybrids. "Shallow" hybrids are described as organisations that have taken on some characteristics of other sectors, such as employing several paid staff or accepting government grants, but ones that are 'not calling into question their basic third sector identity' (Billis, 2010c: 59). "Entrenched" hybridity is characterised by the dominance of paid staff in delivering the organisation's core work, which is usually the result of more significant funding made available through public or private sector sources, and the establishment of a more formalised hierarchical management structure and

way of operating. Billis describes the significant changes to third sector organisations associated with entrenched hybridity and the consequent introduction of features of the firm and bureau:

> 'Formal job descriptions will be required, the notion of managerial accountability will arrive, sanctions and reward systems introduced, systems and procedures will need to be "bureaucratised", volunteers may be seen to be "unprofessional", the organisation will become more complex' (2013: 13).

This in turn leads to further pressures on the organisation to increase its sustainability in order to maintain staffing and consequently makes them more inclined to yielding to public policy needs or market principles to secure resources.

Furthermore, Billis (2010c) differentiates between "organic" and "enacted" hybrid organisations. Organic hybrids are third sector organisations that have undergone gradual organisational change which has taken them away from their associational "roots", resulting in a permanent change of operating principles. Enacted hybrids are organisations which have been purposefully established by other organisations, often public sector bodies. They are close to the third sector boundary and Billis concludes that these are the organisations which most frequently suffer from 'lack of clarity about their fundamental sector identity' (Billis, 2010b: 246). The four analytical categories formed from the two classifications demonstrate the diversity of hybrid organisational models in the third sector.

Hybridisation of third sector organisations is often an attempt to or the effect of diversifying organisational income sources. Hybridity can either be pursued as a deliberate strategy in establishing or transforming an organisation or organisations can "drift" into it through a gradual change of income sources and ways of working. Maintaining a mixed resource base and managing multiple funding streams carries the risk of diverting organisational capacity and resources away from its core service provision to managing, for example, multiple monitoring and reporting requirements (Nevile, 2010). It is important to highlight though, that hybridisation is not necessarily accompanied by "mission drift" although some studies suggest this is a particular risk in "enacted" hybrid organisations and may be the case when "organic" organisations move towards being "entrenched" hybrids (Howard & Taylor, 2010; Hutchinson & Cairns, 2010). Nevertheless hybridisation is also used by third sector organisations as a conscious strategy: applying principles from other sectors could overcome "voluntary failure" (Salamon, 1987) and change the perception of their "amateur" way of working.

> ‘Just as the chameleon is identified by its strategy of changing color, so hybrid organizations could be classified by their strategies, as methods of adaptation to conflicting demands. Accordingly, if there are demands from multiple environments (or multiple demands from the one environment), the strategy will be aimed at reconciling those demands.’ (Brandsen et al., 2005: 760).

Community organisations are commended for their ability to adapt to changing circumstances to facilitate meeting their service users’ needs, however perpetual adjustment and trying to meet contradictory expectations from different stakeholders can make hybridity a source of tensions and disruption. Organisations and the people who work in them have their own “predispositions” towards preferred ways of working related to their values and beliefs which cannot be ignored. Individuals involved in the third sector organisations, either as volunteers or as employees, have certain expectations regarding the “rules of the game” in particular sectors: ‘although sector realities may become hybridized, ideas about sector continue to carry important meanings’ (Lewis, 2010: 223). “Boundary-crossers” – people who come to work in the third sector from other sectors, may be sometimes disappointed by the organisation hybridising and not finding others who will work basing on the same beliefs (Lewis, 2010). Hybridity can therefore be a double-edged sword for third sector organisations.

“Hybridisation” is occurring in an increasing number of third sector organisations, including small community organisations which this thesis focuses on. There is broad agreement that they are increasingly influenced by ways of working typical of the public and private sector, including management techniques, human resources, income streams and accountability mechanisms. The available literature does not however fully consider the practical implications of pursuing the “hybridisation” of community organisations and whether it is achievable for small organisations which work with disadvantaged groups. There is a gap in our understanding of the more intangible aspects of hybridisation, the effect of changing practices on organisational culture, the influence of existing organisational resources and institutional context. As a result, we lack evidence which would support “hybridisation” as a viable strategy for community health promotion organisations achieving autonomy and sustainability.

The following section will provide a theoretical framework for deepening our understanding of the process of change in community health promotion organisations; Bourdieu’s concepts of practice, field, capital and habitus will be introduced as tools for investigating the organisational “black box” and the multiple factors facilitating and hindering adopting new

ways of working. This leads on to the formulation of research questions which aim to address the current gaps in understanding of how organisations manage in current circumstances.

2.7 Organisational practices in turbulent times: a theoretical approach

Community-centred health promotion organisations are currently working in challenging conditions and the impact of austerity and marketization on organisational practices is not well understood. There is a dearth of any previous research relating to community health promotion organisations and little insight into how small, third sector organisations are managing to maintain services despite current pressures. My intention is to explore the role of community health promotion organisations in their local health systems and how attempts to maintain autonomy and sustainability influence their organisational practices. This draws attention to the relation between the organisations and other actors in the local health field. The organisations will be considered both as actors themselves and as entities constructed through individual and collective agency of the people involved, acknowledging the '(m)utual interdependency of person and organization' where '(p)erson and organization refer to each other'(Bouwen, 1998: 305). This requires analysing interweaving layers of social phenomena: on one hand considering the policies, processes, human and financial resources objectively existing as part of the organisations and their context, on the other examining how meanings, beliefs, roles and relationships are constructed and how they operate in practice. Therefore I chose to employ a relational approach in this thesis which can reconcile the objective and the subjective, link the structural and the interpretative and bring together meanings and practices. It bridges these divides and facilitates considering the interplay of various factors by providing 'causal explanation that seeks to avoid both pure voluntarism and structural determinism' (Mutch, Delbridge, & Ventresca, 2006: 608).

In this thesis I use a Bourdieusian theoretical framework to interpret the collected data. It came to light as an appropriate choice during initial data analysis when I noted that "habitus" and "field" were useful conceptualisations of some of the themes that I identified in the data. In the process of more in-depth analysis it became evident that jointly using the concepts of field, capital and habitus and examining the data through a relational lens "fit" the data and was a very productive approach. It builds on previous work of Emirbayer and Johnson (2008) who have presented the considerable advantages of combining Bourdieu's concepts in organisational analysis and Macmillan's (2011) use of these concepts to theorise the "world" of voluntary and community action. It facilitates investigating the tensions between the organisations' culture – their habitus, and the expectations of external stakeholders and allows incorporating social capital, cultural capital and symbolic capital into the discussion about

organisational resilience and power relationships between community organisations and public sector bodies. This theoretical approach has a significant advantage in that it overcomes the dichotomy of agency and structure (Bourdieu, 1990: 56) and allows consideration of the organisational context and the "rules of the game" inherent in the field as well as the purposeful use of various organisational forms of capital to improve its position and gain influence. This thesis will use the theory developed by Bourdieu to portray some of the issues specific to the positioning of community organisations in the health field and to further understanding of how the organisations' ability to remain sustainable and maintain autonomy are facilitated by the characteristics of its culture and social resources.

I will therefore consider the requirements of the organisations' institutional environment and their relationships within it, and how their organisational culture and resources enable or hinder achieving sustainability and autonomy. Drawing on Bourdieu's concepts of field, capital and habitus provides a comprehensive and cohesive theoretical framework for exploring how the social and institutional context, organisational motivations and preferred ways of working and existing resources influence its ability to maintain autonomy and sustainability. These three factors are under-researched, but fundamental to understanding what makes organisations resilient to unfavourable changes in their environment. The following section introduces Bourdieu's theoretical framework, defines his key concepts and explains how they will be used in the analysis of data.

2.7.1 Practice: improvisation and "strategizing"

In this thesis the ways of working adopted by the studied organisations will be conceptualised as practices. "Practice" is a theoretical concept relating to human agency in everyday life, the way people employ their knowledge and understanding of the world to interact with their environment and each other:

> 'Practices are produced in and by the encounter between the habitus and its dispositions, on the one hand, and the constraints, demands and opportunities of the social field or market to which the habitus is appropriate or within which the actor is moving.' (Jenkins, 1992: 78)

The particularity of Bourdieu's approach to the subject is his emphasis on the non-reflexive nature of behaviours describing practices as 'regulated improvisations' (1977: 78). Practices, through habitus, are embedded in frameworks of common understanding and perception associated with a particular position in the structure of a field, however, they may also be independent of any field and be "improvised" according to individual predispositions and

readings of the situation. This approach allows analysis of organisational behaviour that takes into consideration subconscious preferences for certain ways of working (habitus) and the social resources which, to some extent, control the opportunities available to them in their institutional environment. Bourdieu's theory of practice acknowledges that implicit knowledge is a crucial element of the process of production and reproduction of the social world, it is inherent to "practical logic" (Jenkins, 1992: 72). It is acquired through experience, getting a "feel for the game", not through conscious decision-making or deliberation and is therefore manifested solely through action: 'the logic of practice which understands only in order to act' (Bourdieu 1977: 91). This indicates that to understand organisational practice in a period of change, it is important to look at not only the "official" rules of the game, but also the unwritten principles of practice that organisations have learned experientially through their interactions in the field. Overall, practices are automatically attuned to the structures that form them, therefore organisational ways of working will be shaped by a particular set of circumstances and relationships. Consequently, changes in the organisational environment, the "field", may demand new practices, ones that the organisation is not pre-disposed to and/or is reluctant to make. This issue will be further explored in this thesis.

Bourdieu suggests however that that implicit knowledge of the practical logic allows for the pursuit of goals and interests; this is referred to as "strategising". Again, this aspect of his theory goes beyond a purely instrumental interpretation of organisational agency when examining how decisions are made and initiatives undertaken, disputing 'that they do so in the conscious, systematic, and intentional (in short, *intellectualist*) manner expostulated by rational-choice theorists.' (Wacquant, 1992: 24). In everyday life motivations displayed by particular actors vary significantly because they have been socialised into responding to incentives from different spheres of the social world. It is argued that Bourdieu's "strategies" predominantly have as an aim

> 'maximizing symbolic profit rather than economic profit, status or power per se—though these are misperceived as means of achieving symbolic profit—and in the end this equates to nothing other than the desire for social value, dignity, or recognition, to feel important and worthy, in whichever walks of life one finds oneself in' (Atkinson, 2010: 15).

Practices are therefore conditioned by previously acquired inclinations and underpinned by an assortment of tacit meanings and benefits potentially attributed to them. There are insistences though when Bourdieu considers "strategising" to be a deliberate and calculated behaviour –

predominantly in 'times of crises' (Bourdieu & Wacquant, 1992: 131). He identified that reflexive practice occurs 'only when the automatisms have broken down' (Bourdieu, 1990: 91) and is directed by the need for an effective achievement of a desired outcome. However this is only possible if the actors have the minimum economic and cultural capital to perceive opportunities and take advantage of them (Bourdieu & Wacquant, 1992: 126). This is a consideration which is particularly salient for this research; organisations are likely to reflect on and try to consciously change their practices when they feel threatened by changes in their environment and "business as usual" would put them at risk. Determining whether small community-centred organisations have sufficient organisational capital to choose the right strategies and to be able to successfully navigate change is a fundamental issue in this research. The following section will provide further insight into Bourdieu's conceptualisation of "field" which delimitates the realm of organisational possibilities associated with their positioning.

2.7.2 Field: the organisation of power relations

The studied organisations are strongly rooted in the community development field through their approach to health improvement in disadvantaged communities. This is not a field where there are many "stakes" to pursue or in which they would engage with other actors in the daily course of their work, however it has significant influence over their organisational culture shaping their "habitus". Their daily work is situated in the multi-organisational field of health services and additionally they occupy a position in the sub-field of third sector activity. The primary stake in both fields is the finite sum of money available for delivery of services for which the organisations are competing; however in both fields the relationships of power are imbalanced and there is a group of organisations, mostly public sector bodies, which significantly influence allocation of resources. Using Bourdieu's concept of field allows exploring 'how power is embedded in everyday relations and in individual consciousness' (Dobbin, 2008: 62) and how these relations have an effect on the daily work of organisations, their sustainability and autonomy.

A field is formed by 'a set of objective, historical relations between positions anchored in certain forms of power (or capital)' (Wacquant, 1992: 16). It 'is not the product of a deliberate act of creation' (Bourdieu & Wacquant, 1992: 98) but emerges from conflict and competition between different agents organised around particular interests or stakes – a prized but limited resource. The health field is complex, with both NHS organisations and local authorities bearing some responsibility for how it is organised. The key stake is financial resource, but there are other interests which are also subject to rivalry. As discussed earlier, health and

health promotion are contested areas, therefore having power over how "health" is defined and what types of services are worth investing in gives considerable influence to commissioners. Also access to service user populations and to facilities can be subject to competition, as some individuals and organisations may be protective of their areas of influence.

Bourdieu's "field" is fundamentally different from the approach of classical structuralism – the 'regularities it follows are not explicit and codified' (Bourdieu & Wacquant, 1992: 98). The structure of the field is determined by the distribution of power within it – positions are relational based on access to particular "forms of capital" (Bourdieu & Wacquant, 1992: 97). The distribution of power in the health field is an important consideration in this thesis. Overall, the characteristics of the field, the "rules of the game" established in it, determine how accessible funding is for community organisations and how much autonomy they have in delivering services. The studied organisations aim to be intermediaries between disadvantaged communities and the state, however they can only truly fulfil this role if they are able to have some influence in the field. The actors in positions of power may or may not be attentive to feedback given by organisations regarding the needs and preferences of service users and allow the organisations to be flexible in how they deliver the contracted services. However the distribution and importance of particular forms of capital within a field is subject to change, thus allowing for repositioning of agents within a fluctuating equilibrium. This indicates that the field can be changed from within as particular actors accumulate capital and the ability to influence the "rules of the game". This is a particularly useful perspective for examining the changing nature of the local health fields in a time of public sector funding cuts and institutional reform.

The behaviour of particular actors within dynamic fields is generated through the interrelationship of their capital (assets and competencies) and habitus (embodied predispositions) (Swartz, 2008: 47). This can be attributed to a dualistic relationship between field and habitus. On one hand the habitus is 'the product of the embodiment of the immanent necessity of a field', on the other it 'contributes to constituting the field as a meaningful world, a world endowed with sense and value, in which it is worth investing one's energy' (Bourdieu & Wacquant, 1992: 127). It is therefore suggested that the habitus is "constructed" through experience and gaining knowledge of the social world and the outcome of this process is determined by the individual's position within a social space. The relationship between Bourdieu's conceptualisation of field and capital and between field and habitus will be further

discussed in the next sections. It is however worth noting here that community health promotion organisations are generally on the periphery of the health services field, therefore their organisational practices will only be influenced to some degree by the habitus generated by this field. This can potentially lead to tensions between the values and views held by the organisations and the motivations and principles embedded by other actors in the health field. It is therefore important to consider whether organisations having the opportunities to secure or improve "room" for themselves in the field. This requires having 'an acknowledged role and position, based on a context-specific, ongoing, sometimes awkward and contested accommodation between similarly placed organisations operating in a given catchment area' and 'a capacity to continue its activities to pursue its aims' (Macmillan, 2011: 23). This is crucial for organisations maintaining their independence of purpose (Independence Panel, 2011).

2.7.3 Capital: resources for organisational positioning

Capital, in Bourdieu's theoretical framework, can be broadly defined as any type of power resource in the field (Swartz, 2008). It is not an object (although it can be constituted by material resources), but a social relation and therefore it 'does not exist and function except in relation to a field' (Bourdieu and Wacquant 1992: 101). Capital operates in particular ways in different fields and I am interested in gaining better insight into what types of organisational resources are valued in the health field and consequently how organisations can use their capital to try to improve their positioning.

Bourdieu (1986) recognises three main forms of capital: economic capital, cultural capital and social capital, however asserts economic capital, the financial means or property rights accessible to individuals, to be the source of the other two. Cultural capital, which is acquired predominantly in the process of socialisation and education, exists in three forms: the embodied state (enduring and internalised dispositions of the mind and body), the objectified state (in the form of material objects of culturally assigned value) and the institutionalized state (certified cultural competence through qualifications). Social capital is the aggregate of benefits available to an individual through their network of established interpersonal relationships and group membership. This endows them with recognition and credibility which are mutually reaffirmed through social interaction and exchange. Bourdieu and Wacquant (1992) also introduce the notion of symbolic capital. This is the status attributed to individuals as a result of possessing one of the three forms of capital when its significance is acknowledged by others – it emphasizes the importance of social recognition as the ultimate goal of individual actors. The distribution of different types of capital within a field represents the structure of the social world (Bourdieu, 1986).

The different types of capital may have varying significance in different fields. Economic capital, although of key importance for community organisations, is of less interest in this thesis than the other forms, because community organisations generally have little of it in their own right. They are dependent on other organisations in the field for a large part of their income, therefore it can be assumed that it is the other forms of capital which determine how well organisations are able to gain financial resources from public sector bodies and other sources. Possessing the "right" kind of capital, such that is effective and valuable in a given field, gives particular agents the ability to enter the field and to exercise influence over it (Bourdieu & Wacquant, 1992: 98, 107). The actors in a field position themselves according to the volume and type of capital possessed – these determine not only their relative power in the field, but also their strategic orientation aimed at preserving the existing distribution of capital or challenging it (Bourdieu & Wacquant, 1992: 99, 109). Strategies are influenced by the perception of the field from the position where the agents are situated (Bourdieu & Wacquant, 1992: 101).

Field theory indicates that fields are made up of "incumbents": those that have significant power over shaping the field according to their interests and "challengers": those who have less prominent positions but despite not being able to have much control over its operation 'can usually articulate an alternative vision of the field and their position in it.' (Fligstein & McAdam, 2011: 6). The supreme form of power is being able to influence which types of capital are most highly valued in the field – this ultimately will be held by the funding bodies, however their perceptions can be influenced by others who may be recognised as important players at a given time. Macmillan names the following resources relevant to third sector organisations: 'tangible resources such as funding and physical resources, but might also include intangible assets such as legitimacy, status and reputation, information, influence and connection' (Macmillan, 2011: 21), all of which are a result of organisational ways of working. This thesis aims to increase understanding of the capital that enables community health promotion organisations to successfully adapt to changing circumstances and improve their positioning in the field. I will be examining the organisations' operational capacity, social capital, cultural capital (particularly the embodied and institutionalised form), and symbolic capital to establish their influence on organisational practices and their ability to achieve sustainability and autonomy.

2.7.4 Habitus: organisational preferences and predispositions

Habitus was developed by Bourdieu as a conceptual tool for overcoming the dualism of agency and structure, to bring together the consideration of subjective perceptions of individuals and

the objective structures of the social world, the micro and the macro level, and therefore 'is central to his methodology of structuralist constructivism' (Reay, 2004: 432). Habitus denotes the perceptions, predispositions and competencies which people are equipped with and are referred to by Bourdieu as 'cognitive and motivating structures' (Bourdieu 1977: 78). Individuals become "socially competent" through subconsciously developing these dispositions in the process of socialisation – owing more to experience than purposeful learning (Jenkins, 1992: 76). Proficiency is reached when patterns of behaviour are replicated and interpreted 'as a matter of routine, without explicit reference to a body of codified knowledge' (Jenkins, 1992: 76). Habitus therefore structures practice according to the principles embedded in a given field. In this thesis it provides a linkage between culture, capital and context which jointly form the mechanism generating practice. It also necessitates considering the permanent and subconscious nature of the cultural preferences shaping organisational ways of working.

An important feature of individual habitus is its embodiment; it is not manifested solely through mental predispositions. Habitus is described as a 'set of historical relations "deposited" within individual bodies' (Wacquant, 1992: 16) and through it 'the social is inscribed in the body of the biological individual' (Bourdieu, 1985b: 113 in: Reay, 2004: 433). It is expressed in "bodily hexis", in how actors physically hold themselves and interact with the environment, for example in posture, gestures or manner of talking (Bourdieu, 1977: 93-94). These "ways of being" are external manifestations of individual identity which are visible to, and can be "decoded" by others. Habitus is individual to each person, their choices and behaviours manifest their upbringing and the objective circumstances of their family and social group (Sweetman, 2003). Habitus 'reflects a shared cultural context' (Adams, 2006: 514) and in this way it comprises the whole history of social groups (Reay, 2004) with interacting actors firmly embedded in established social frameworks which shape and define their relationships.

> 'Social agents are the product of history, of the history of the whole social field and of the accumulated experience of a path within the specific subfield.' (Bourdieu & Wacquant, 1992: 136).

Habitus acts as an indicator of whether people "fit in" with others in the field, whether they have the capital resources valued in a given field (Bourdieu, 1984: 95). Consequently it delineates the realm of possibilities available to individuals in a field and those perceived by them as achievable, but also may potentially limit their ability to gain access to it or have influence over it.

In this research "habitus" will be a valuable tool for examining the individual predispositions of people in the studied organisations. However analytically a "habitus" can also be attributed to a collective and therefore it will be the basis of examining particular aspects of organisational culture. Habitus is shared in social groups as it is derived from and formed by social structures, the "objective" patterns of social life, and is continually reproduced as "the way things are done" when people apply 'schemes of perception, appreciation and action, which are acquired through practice' (Bourdieu, 1990: 95). It produces and gives meaning to organisational practices, contributing to cohesion and a sense of direction:

> 'One of the fundamental effects of the orchestration of habitus is the production of a commonsense world endowed with the *objectivity* secured by consensus on the meaning (*sens*) of practices and the world, in other words the harmonization of agents' experiences and the continuous reinforcement that each of them receives from the expression (…) of similar or identical experiences' (Bourdieu 1977: 80)

The concept of organisational habitus has been adopted in organisational studies and recognised as an alternative to "organisational culture", however it is used largely for the purpose of examining it as 'contested terrain' and the 'dynamic nature of the organizational culture, which is the result of the continuous power struggle/game between different agents in the organization' (Özbilgin & Tatli, 2005: 864). Although I do not deny that conflicts and power struggles occur in community health promotion organisations, these were neither the focus of my research, nor did they become apparent in the course of my fieldwork. On the contrary, in each organisation I observed a cohesive organisational style of working and of being, one which I would argue is much easier to maintain in relatively small, informal organisations than in larger, more complex entities which are the typical subject of organisational studies. Organisational habitus is self-perpetuating as organisations attract and recruit, deliberately, or unknowingly, people who "fit" their way of thinking and working as they will be naturally perceived as "one of us". Likewise people choose to join organisations that "feel right" and are a comfortable environment where they can easily achieve common understanding:

> 'Social reality exists, so to speak, twice, in things and in minds, in fields and in habitus, outside and inside social agents. And when habitus encounters a social world of which it is the product, it is like a "fish in water": it does not feel the weight of the water, and it takes the world about itself for granted.' (Bourdieu & Wacquant, 1992: 127)

However, organisational habitus is not set in stone, it remains 'an open system of dispositions' (Bourdieu & Wacquant, 1992: 133) which are continuously subject to the influence of life experiences and the social environment, and can be consciously adapted when there is a mismatch between established perceptions and dispositions and the social reality they encounter. Bourdieu points out that 'in rapidly changing societies, habitus changes constantly, continuously', albeit 'within the limits inherent in its originary structure' (Bourdieu, 2002: 31 in: Sweetman, 2009: 508). Sweetman suggests that in modern, rapidly changing – and one may add diverse and mobile – societies the mismatch of habitus and field may be a common experience and a taking a flexible approach to identity construction may have become for many a 'structural requirement' (2009: 495). In circumstances of institutional reform, shifting policy priorities and changing "rules of the game" in the health field reflexivity (here understood as a conscious and continual effort to construct and/or redefine one's identity and practices) becomes 'part of the repertoire of the habitus' (Jenkins, 1992: 77) for community health promotion organisations and begins to 'operate in a taken-for-granted way, or as a matter-of-course' (Sweetman, 2009: 496).

The notion of a 'reflexive habitus' (Sweetman, 2009: 495) is therefore useful in explaining changes to organisational culture and in the ways of working in the studied organisations. Health services are driven by shifting policy priorities and therefore change is a "structural requirement" for organisations in this field, generating a "reflexive habitus" – a predisposition to adapt and re-evaluate practices to the current requirements of the environment. The studied organisations have already demonstrated this – all three transitioned from their initial status as projects within the public sector to independent entities. Therefore it can be expected that as they experience pressure from their institutional environment to alter their ways of working, their practices will undergo some transformation. However the extent to which organisations actually have a "reflexive habitus" and their ability to meet external expectations is under question in this thesis.

2.7.5 A "hybrid habitus": reconciling different "ways of life"

In this thesis I conceptualise organisational culture as its habitus. Habitus is 'particularly useful for scholars who are studying dimensions of culture in organizational settings, since it may serve as a more critical alternative to the concept of culture.' (Özbilgin & Tatli, 2005: 863). It highlights the interplay of individual dispositions and structural influences. Organisations are a field in their own right (Emirbayer & Johnson, 2008), therefore generate their own habitus. Each person comes to the organisation with a unique set of previously acquired experiences, knowledge and perceptions. These are then negotiated in the process of collective "sense-

making" within the organisation: 'creating and sustaining images of a wider reality, in part to rationalize what they are doing (…) reading into their situation patterns of significant meaning' (Morgan et al. 1983: 24 in: Weick, 2001: 11). Habitus is the source of organisational culture - 'the shared rules governing cognitive and affective aspects of membership in an organisation, and the means whereby they are shaped and expressed' (Kunda, 1992 in: Alvesson, 2002: 3), it therefore determines the accepted practices and discourses. The lens of "habitus" allows tracing organisational ways of working to their own positioning in the structure of the social world. Organisational habitus is therefore elusive and adaptable but also path-dependant and embedded in its wider social context.

Organisational habitus (culture) is fundamentally 'about how organizations work' as it is enacted through 'organizational structure and operation' (Hood, 1995: 209). Community health promotion organisations have a strong sense of purpose which is associated with their values, their beliefs about health and perceptions of social processes; how values are acted upon is often considered to be the source of distinctiveness in how third sector organisations deliver welfare services (Blake, Robinson, & Smerdon, 2006; Jochum & Pratten, 2008). As suggested in the theorisation of habitus, the structure of an organisation and its values and beliefs must be in a mutually supportive relationship for the organisational model to be "viable": 'capable of cohering, attracting loyalty, and surviving over time' (Thompson, Ellis and Wildavsky 1990: 1-2 in: Hood 1998: 10). This once again suggests that organisations may find it challenging to adapt their practices to ways of working from other fields.

Hood (1998) introduced Cultural Theory to the discipline of public management to capture and conceptualise the cultural variety in the organisation of public services. This theoretical framework describes four different "ways of life". They designate distinct ways of perceiving and organising a social system described by analytical categories of "grid" (the extent to which a culture imposes rules and classifications on its people) and "group" (the extent to which individuals are influenced by group norms), each implying a different form of power-relations. Applying this to Billis' (2010c) sector 'ideal types' allows us to see that each one has it's ideal-type "way of working": the "Hierarchist Way" in the public sector, the "Individualist Way" in the private sector and the "Egalitarian Way" in the third sector.

Table 1: The grid-group dimensions of culture adapted from Hood (1998)

		GROUP DIMENSION	
		High in group cohesiveness	Low in group cohesiveness
GRID DIMENSION	High in predetermined rules	*The Heirarchist Way* (Public sector) Socially cohesive, rule-bound Managed by oversight	*The Fatalist Way* Low co-operation, rule bound Managed by contrived randomness
	Low in predetermined rules	*The Egalitarian Way* (Third sector) High-participation structures in which every decision is "up for grabs" Managed by mutuality	*The Individualist Way* (Private sector) Atomised approaches to organisations stressing negotiation and bargaining Managed by market competition

These "ways of life" can be conceptualised as distinct types of habitus which shape practice in the three sectors and each sector forming a distinct field with its "rules of the game". The egalitarian habitus is fundamental to the community development approach to health promotion, a way of delivering public services that is distinct from approaches typically taken by other sectors and that may lead to achieving broader social outcomes as well as helping people improve their health and wellbeing. The studied organisations are however working in an environment that is dominated by public sector actors and the externally set "rules of the game" are becoming increasingly close to market conditions. They are compelled to adopt practices associated with "ways of life" different than their own to remain sustainable, integrating new cultural elements and developing what I will refer to as a "hybrid habitus".

Applying a hybrid organisational model to small community organisations such as those delivering health promotion services in disadvantaged neighbourhoods is highly promoted by policymakers, but its feasibility is in need of verification. Policymakers and commissioners rarely appreciate that values, beliefs and drivers underpinning organisational ways of working contribute to organisations' success in community health promotion work. Overall, there is little awareness of how small community organisations experience and manage hybridisation – what happens in the organisational "black box" (Westall, 2009). It is therefore crucial to gain better insight into how the organisations' core principles are affected by taking on ways of working typical of other sectors and whether hybridisation could be a potential route to autonomy and sustainability for community health promotion organisations.

2.8 The research problem

This study of community health promotion organisations working in disadvantaged areas is particularly timely; tackling health inequalities is a national policy priority, yet equally an area of competing approaches in which community development methods seem underappreciated and absent. The studied organisations' intermediary position between the disadvantaged communities they serve and public institutions which have statutory responsibility for population health makes them well placed to deliver services, yet vulnerable to competing pressures and priorities. Their preferred way of working creates opportunities for individual and community engagement, empowerment and collaboration, but also generates significant tensions with more "mainstream" health services. This thesis aims to address the shortage of empirical research regarding how community health promotion organisations were being affected by these changes and how they were managing to continue delivering their services in circumstances of marketisation and austerity.

how community organisations working in health promotion make sense of current circumstances and how they are trying to adapt their practices to achieve greater autonomy and sustainability.

The presented theoretical framework will be applied to attend to some of the gaps in current knowledge about organisations working in health promotion and the factors that are significant to these organisations achieving autonomy and sustainability in a changing and increasingly unreceptive environment. Applying Bourdieu's concepts of habitus, field and capital facilitates identifying and exploring the organisational strengths and limitations in achieving autonomy and sustainability. This theoretical framework indicates that organisational autonomy (i.e. being able to determine their own organisational practices relating to how they fulfil their mission) and sustainability (i.e. being successful in securing the resources to continue their activities) are predominantly dependent on the organisations' position in the field and equally their ability to implement practices which comply with the "rules of the game", which in current circumstances implies a degree of hybridisation. This suggests that organisational habitus and capital are fundamental to their success.

The core focus of this thesis is identifying the factors that support or hinder organisational efforts to achieve sustainability and autonomy in a changing landscape of public service delivery. To achieve this I will consider their relationships with external stakeholders and positioning in the field and furthermore, how their organisational culture and capital influence their ability to adapt their practices to changing circumstances. Consequently, I will establish

whether community health promotion organisations can successfully integrate ways of working from different sectors into their organisational practices, i.e. hybridise, to improve their sustainability and autonomy as is often assumed in policy and commissioning practices.

Therefore this thesis addresses the following three questions:

- How are the organisations affected by circumstances of austerity and marketisation of public services?
- What are the factors that support or hinder achieving sustainability and autonomy?
- Is hybridisation a feasible strategy for third sector organisations providing health promotion services in disadvantaged neighbourhoods?

The findings of this research will provide new insight into how organisations develop responses to unfavourable political and economic conditions, further understanding of the processes leading to marginalisation of community health promotion and offer a new perspective on the hybridisation of third sector organisations which takes into account organisational culture and capital.

Chapter 3

Opening the "black box": the research methodology

To answer the research questions three case study organisations were chosen and an ethnographic approach was used for data collection. This chapter describes the research methodology, the design and the case study organisations. It details the methods used and provides an account of data collection and approach to its analysis. It also provides some reflection on my experiences as a researcher and the challenges and limitations associated with this research.

3.1 Research methodology: ethnography

Pursuing the aim of a holistic and relational analysis has led to choosing ethnography as the research methodology. Identifying the generative mechanisms of organisational practices, as discussed above, is dependent on capturing the interplay between contextual factors and individual incentives, understanding "ways of being" and relationships. An ethnographic approach, which is acknowledged to be effective in studying organisations, was therefore chosen as the most appropriate for the study. However obtaining a relational perspective demands considering not only the behaviours of actors in the context of the research "site", but also their positioning in the wider social world:

> 'a truly relational approach to ethnography demands cognisance on the part of the researcher that the actors in question interact not only in their concreteness but also as occupants of positions in a structure of relations (and thereby as bearers of different types of dispositions from within a space of dispositions).' (Emirbayer & Johnson, 2008: 34)

I therefore studied the organisations, but also tried to experience and reflect on the characteristics of their localities: the geography, demographics, physical environment and local cultures and mindsets, to grasp the nuances of the specific spatial, social and economic conditions that they operated in. I achieved this through trying to learn about local history, occasional reading of local newspapers and casual conversations with research participants and other "locals", but predominantly by immersing myself as much as possible in the local setting through wandering around neighbourhoods when not with the organisations directly, using public transport and going to local shops and retail centres. The nature of this methodology is that the researcher becomes inevitably part of the studied setting to enable

'writing about the world from a standpoint of participant observation' (Burawoy, 1998: 6). This allowed me to explore the richness, depth, and complexity of organisational life, telling the story of each organisation, but also, to some extent, the stories of the people involved and their communities. This holistic approach was facilitated by a case study design which is further discussed in the next section of the chapter.

3.2 Research design: a multiple case study

The purpose of this study is to discover the internal and external factors that support or hinder organisational sustainability and autonomy and gain understanding of how they are interrelated. It therefore requires investigation of contextual factors and processes within the organisations themselves. A case study design was chosen for the research; in policy-related research qualitative case studies are particularly applicable where questions are asked about how or why projects or events take a particular course (Keen & Packwood, 2000) and when in-depth, explanatory description is needed (Yin, 2009). The researcher can consider not just the voice and perspective of the individuals involved, but also of the relevant groups of actors and the interaction between them:

> 'macro- and meso-level effects manifest in micro-level meaning and actions, thus showing how case studies and ethnography can account for the situated nature of social action: the interaction of actors as position occupants in a structure of relations and the broader system of organizations within which an event or activity is located.' (Vaughan, 2008: 77-78)

The case study design enabled capturing the different viewpoints and understandings of the studied organisations' situation and how their external stakeholders contributed to it. Some other strengths of the case study method stem from its inductive approach to exploring processes; it opens the possibility of deriving new hypotheses through observing multiple aspects of the studied phenomenon and allows for clarifying theoretical concepts where they require contextualization (George & Bennett, 2005).

The research project was carried out as a multiple-case study with each case following a similar course of fieldwork. This was inspired by the Third Sector Research Centre's "Real Times" project:

> 'Studying a range of cases affords some protection against findings that might be considered to be purely idiosyncratic. The group of case studies should be regarded as broadly reflective of a diverse range of third sector activities and the

> range of contexts in which they occur, rather than statistically representative in any way, supporting a claim that selected cases are not untypical of the kinds of activities, organisations and, more importantly dynamics, found in the sector.' (Macmillan et al., 2013: 5)

As community health promotion organisations are an understudied field, it was difficult to determine what a "typical" case would look like, therefore investigating several cases gave better insight into the diversity of factors which contribute to the organisations' approach and an attempt to gauge their significance in each case. It allowed for analysis within cases as well as cross-case analysis aimed at identifying key similarities and differences between them. The fieldwork consisted of three case studies with the organisations being the main unit of analysis. I felt that this provided a good balance between diversity of cases and feasibility. The scope of the case studies included the organisations and their embedded units (i.e. staff members, processes and projects), their context (i.e. external stakeholders, other organisations, and their social environment) and the relationships they form within that context. Theoretical sampling was used, meaning that the cases were picked with regard to their "theoretical potential" not for their representativeness of a given population. This approach defined both the selection of particular organisation as "cases" as well as the choice of particular respondents for interview and situations for observation.

Recruitment of case study organisations was not possible via a systematic search because there was no single national listing of community health promotion organisations. I identified several bodies that worked with and supported such organisations (The Big Lottery Fund, The King's Fund and the National Healthy Living Alliance) and searched via their provided links and records. I also searched directly through the search engine Google by entering combinations of search terms such as "health", "wellbeing", "healthy living", "community development", "social prescribing", "project" and "centre". I established the following criteria for including organisations in the study:

- independent (i.e. not part of the NHS or a local authority)
- organisational aims referring to health improvement in a local area (without focus on any particular social group or specific health condition)
- applying a community-centred approach to health and wellbeing (South, 2015: 15)
- working in an area which includes LSOAs classified as 3% most deprived neighbourhoods in England (Index of Multiple Deprivation score) according to 2010 data.

I stopped my search after identifying nine organisations which met these criteria. I then chose four which provided variety in terms of the organisations' geographical location, size and characteristics of communities served (ethnicity, urban/suburban) and approached them with an invitation to participate in the research. Of these, Health Connections and Healthy Millborough agreed to participate. Once my research with them was in progress, I approached two further organisations which I considered would add further variety to the sample and Overton Wellbeing Group confirmed their willingness to participate. At this point I decided that I will have sufficient material from three organisations and did not make attempts to recruit further ones.

3.3 Description of studied organisations

The case study organisations and individual participants were prescribed pseudonyms to maintain their anonymity, with names of locations and any other identifying characteristics removed or made more ambiguous. All have had some national publicity, being recognised through sector awards or academic studies, for the positive impact of their work. This was not a criterion when recruiting the organisations, however it indicated that their approach to health improvement in disadvantaged communities is effective and there is good practice to be shared from their work. The studied community organisations shared a common background of starting off as local authority and/or NHS projects funded by funding grants within public bodies: Health Connections and Healthy Millborough had lottery money and Overton Wellbeing Group was financed from a New Deal for Communities grant. In each of the cases when that particular funding came to an end and their host bodies decided to withdraw from the projects, they made the decision to continue their work as independent organisations.

Table 2: Overview of case study organisations

	Health Connections	**Healthy Millborough**	**Overton Wellbeing Group**
Region	Yorkshire	North West	South East
Area served	Suburban and semi rural ward	Urban local authority area	Estate on outskirts of city
Population served	Are of mixed affluence, some ethnic minorities	2 white working class and one predominantly South-Asian neighbourhood	White working class
Formal status	Registered charity and company	Registered charity and company	Unregistered, formalised as a local

			residents committee
Human resources	24 part-time employees and some volunteers, management committee/trustees	8 part-time employees and some volunteers, management committee/trustees	8 volunteers (till March 2012 supported by council community development worker)
Budget 2011/2012 (approx)	£450,000	£450,000	£8,500
Core services	Outreach work with underserved groups, promoting access to NHS services such as screening, building social support networks, improving nutrition and exercise groups	Management of two community gyms, exercise groups, nutrition, overseeing local food cooperative, finding solutions to local health problems through community engagement projects	Exercise and social groups for the less mobile, elderly and isolated, health consultation/smoking cessation drop-ins and healthy catering for local community events

3.3.1 Health Connections

Health Connections is a charity with about twenty part-time employees working in a suburban and semi-rural ward in Yorkshire (see photos in Appendix B.2-B.5). It serves an area of mixed affluence with some ethnic minorities; mainly south Asian, but also refugees. It was initially established within the local PCT through lottery funding. Their key areas are outreach work with underserved groups, promoting access to NHS services such as screening or ante-natal consultations, building social support networks, nutrition and exercise. It is the largest of the organisations and has been expanding since it became independent. It has maintained some core funding from the NHS, but now also employs support staff in fundraising and communications/marketing roles who have successfully contributed to gaining new sources of income. It has developed a very professional image, is now a recognised local "brand" and has received several awards which are well recognised in the health sector, which has strengthened its position and is regarded locally as a bit of a 'big fish in a shrinking pond'.

The organisation has a very strong sense of its identity based on a community development ethos, but this is combined with a strong entrepreneurial spirit and proactive approach to getting new funding. Organisational leadership is characterised by a clear vision of their purpose and a strategic approach to long term planning. It benefits from working in an area of mixed affluence and proximity to a large metropolitan centre – this means that they are able

to recruit “high quality” trustees, staff and volunteers with good social and cultural capital, which in turn facilitates building relationships with key stakeholders and understanding the requirements of funding agencies. Their key NHS commissioners are becoming increasingly target-driven and limited in the types of services they will fund, and there is uncertainty whether the GP consortia will continue to fund them, however overall, public agencies in the area have an established record of working with community organisations and some willingness to support them. There is also a well organised local network of third sector organisations working in health and wellbeing which has some influence over local agendas and how public sector agencies perceive health needs.

3.3.2 Healthy Millborough

Healthy Millborough is a charity with eight part-time employees which works in Millborough, a former mill town in the North West. Its thriving industrial history is evident in the historical town planning and architecture, but having suffered rapid deindustrialisation in the mid-20th century, it is visibly dilapidated. Despite regeneration efforts the town centre is quite lifeless and lacks community feel – it is dominated by a large shopping centre and an office tower which houses council offices (see photo in Appendix B.6). At the time of the study Healthy Millborough was focusing on working in three deprived neighbourhoods – two are relatively remote white council estates (see photo in Appendix B.7) and one that adjoins the town centre and has a 90% South Asian population (see photo in Appendix B.8).

The organisation was also originally set up through a lottery project hosted by the local authority and the PCT. It is successfully running two community gyms together with exercise groups and a local food cooperative coupled with cooking classes, has championed successful cancer screening campaigns and has projects focusing on community engagement in addressing local health problems. Healthy Millborough grew initially as an organisation after becoming independent, however it had lost nearly all its NHS and LA funding in 2011 leaving it with only lottery funding to cover core costs. It therefore laid off several members of staff and the remaining 8 reduced their working hours to save a post. There is a very tangible feeling of uncertainty of the organisation’s future and whether they will be able to lift themselves back up. There is some funding available from statutory bodies for community health promotion and they are the only third sector organisation in town which delivers health promotion through community development. Nonetheless they struggle to get significant local funding, despite winning an award and considerable success of several community initiatives which are now self sustaining.

They perceive the bureaucratic system as unfavourable, funding has been withdrawn locally from community work in recent years and competition within the third sector for public funds is very strong. There is not quite enough capacity to develop the organisation and new income streams. They try to maintain a professional image but, for example, their website was out of date for almost 3 years and they are largely reactive when it comes to sourcing funding. The organisation's managers are very driven, very involved in front-line work and have very good relationships with community members and their team, but they lack certain skills and predispositions to be credible partners for many external agencies. The trustees are mostly people who have roles in stakeholding organisations, and all are part of the same relatively closed network. Healthy Millborough as an organisation has a relatively low social/cultural capital. Finally they face strong resistance to collaboration from local NHS organisations which is associated with a perceived lack of recognition by most health professionals of the work they do. They therefore have a very limited ability to influence local agendas.

3.3.3 Overton Wellbeing Group

Overton Wellbeing Group is a local resident group run by a committee of eight volunteers based in Overton, a white, council estate on the periphery of a major, relatively prosperous city in South East England (See photos in Appendix B.10 – B.11). It was developed as a volunteer-led support arm of a council and PCT neighbourhood project funded through the New Deal for Communities programme and it was originally led by council community development workers.

In March 2012 when the city council withdrew its remaining part-time community worker from supporting that project the volunteers took over the full administration of all the delivered activities. They organise exercise and social groups for the elderly and isolated, hold regular health consultation drop-ins and provide healthy, homemade catering for a range of community events. These volunteers have all been involved for 6-10 years and over this period of time undergone formal training which gave them the knowledge and skills to deliver these activities. They are all in the 60+ age group and, coincidently, each of them had personal experiences of serious health problems. They were involved in the organisation because they were interested in working in the community and aware that their health and wellbeing have also benefitted from their engagement and social contacts formed through this voluntary work. The committee members were not particularly keen on performing administrative duties and searching for funding – the existing paperwork and formal arrangements were already perceived as a significant burden. Therefore they decided that they were not interested in

setting up the organisation as a formally registered charity and working close to a social enterprise model, which was suggested to them by the council.

Overton Wellbeing Group were very proud of their independence and ability to continue delivering services on their own, however their long-term sustainability is questionable. Their funding is largely based on a small community grant which was due to finish in 2015 and the costs of running some activities were already wholly or partially covered by the small charges placed on participants. Their other key difficulty is that the volunteers form a quite close-knit and "closed" group and it is recognised that they are having difficulties in getting any new volunteers involved. They have a very low public profile in the local area and although their work has attracted some attention nationally, they have limited relationships with other local organisations. There is almost no recognition by statutory bodies and health professionals locally of their work. Therefore their sustainability is questionable, but also the impact of their work is limited to the small group of service users they are able to cater for. They have no resources to effectively develop their services and are unable to bring about any broader change in the neighbourhood.

3.4 Methods

Each case study organisation was investigated using a variety of data collection methods. The study was initiated by desk research. Data and information on health outcomes and social factors in each area were accessed. This helped to identify the health promotion needs of the population, possible health inequalities and any potentially significant demographics in the area. In addition documents produced by and about the organisation were accessed, including any available internet resources such as websites. This included mission statements, contracts, annual reports, marketing and publicity material, evaluations and data regarding service delivery. On a very basic level this allowed me to "immerse" myself in the case, broaden my understanding of its activities, the issues they encounter, and how the organisations present themselves through text. These therefore served as leads for further investigations.

The key phase of the study consisted of interviews and participant observation. The interviews were semi-structured and there was an interview guide constructed for each group of respondents. The interview guides were treated as a list of problems to discuss and were not strictly followed – please see Appendix E. The questions asked were generally broad and open-ended and therefore allowed respondents talk about aspects of the organisation's work which they perceived as significant. It was therefore possible to find out how people spontaneously describe the work done by the organisations and how they perceived its current situation. The

semi-structured nature of interviews also permitted following the respondents' line of thought when asking in-depth questions to better understand underlying assumptions and perceptions.

It was agreed with the research participants that my role when visiting the organisations would not be of a removed observer, but where possible and appropriate I would get involved, either by helping or participating in their activities. This allowed me to take on roles of both "service user" and "volunteer" which contributed to a deeper understanding of the practical aspects of their work, relationships within the organisation and to get a subjective "feel" of the atmosphere within the organisation. Participant observation also facilitated informal interaction with service users and staff. This was an invaluable way of gaining knowledge of the organisations' services and building relationships with the staff, both of which improved the quality of data collected through interviews. When possible, field notes have been made during observation or they were written up on the same day. Their content is factual, for example regarding the socio-demographic description of service users, records of events and reflective where individual behaviours or interactions were recorded and an attempt made to interpret how participants made sense of particular situations (Bowling, 2009). These notes were supplemented by photographs taken of and in the organisations' buildings and neighbourhoods they work in (see Appendix B). This was to assist in documenting the visual qualities of places and details of items displayed by the organisations. Field notes provided raw material for analysis and the process of coding and categorising the data corresponded to the one used for interview transcripts as described below.

During the course of fieldwork it became apparent that individual interviews with staff members would not necessarily allow me to access the deeper held meanings, values and perceptions. I therefore organised a "creative workshop" for community staff members where they were asked to jointly create a collage. The application of this research method to explore identities and relationships is supported by the work of David Gauntlett (Gauntlett & Holzwarth 2006; Gauntlett, 2007). It 'recognises and indeed embraces the creativity and reflexivity of people (…) it offers them tools through which they can thoughtfully communicate their own meanings and understandings.' (Gauntlett, 2007: 85) He argues that abstract experiences are communicated more easily when mediated through something physical (Gauntlett, 2007) and that through the process of making something people increase their engagement and connection with their social environment (Gauntlett, 2011). Using metaphors is significant to this method as they 'enable people to capture complex ideas, often with a

number of facets, in simple visual form' (Gauntlett, 2007: 151). I provide details of how I applied this method in the following section.

The final stage of engagement with the case study organisations was a presentation of initial findings from fieldwork to staff and trustees. This is what Burawoy refers to as a "valedictory revisit" used to gauge the subjects' reactions to the reported research results.

> 'This final engagement with the people one studies, confronting them with one's own conclusions, deepens both constructivist and realist insights into the world we study.' (Burawoy, 2003: 673)

The aim was to involve them in a discussion about the results and obtain feedback on the interpretation of data, with the possibility of further considering key questions and views present in the organisation. This was also a way of also ensuring that no important issues were omitted in the research and serious misinterpretation was avoided increasing the validity of the findings.

3.5 Ethical considerations and ethical practice

I sought approval from the Faculty of Social and Human Sciences Research Ethics Committee for carrying out this research and following this application process was useful in highlighting the key ethical considerations:

- Informed consent: All research participants were given an information sheet outlining the research (Appendix C). The organisations' managers acted as "gatekeepers" to each organisation, and signed a consent form in their name (Appendix D). Then written consent was sought from interview and workshop participants and for particular activities from those leading them. Activity participants were introduced to the researcher at the start of the activity and verbally informed about the study to seek their verbal consent for participation.
- Anonymity and confidentiality: The organisations, locations and participants have been given pseudonyms to protect their anonymity – please see Appendix A for the basic person profiles of the individuals mentioned or cited in this thesis. Any detailed information which may identify the participating organisations (such as the names of the national awards they received) has been withheld in the reporting of findings. Verbatim quotes have been edited (with substitute phrase in parentheses) where their content referred to individuals, places or other identifiable details. Any sensitive information

which was intentionally or unintentionally disclosed to me and events of personal nature that took place in my presence were kept strictly confidential.

- Data security: Digital recordings, transcriptions and photos have been stored on a password-protected computer.

However obtaining the committee's approval for the study was only the first step – keeping to the principles of ethical research was an ongoing process throughout the period of fieldwork. The "disorganisation" of my fieldwork (detailed in the next section) had implications for managing the formal ethics approval process. As the research design was intended to be developed in the course of fieldwork I initially sought ethics approval only for interviewing staff and external stakeholders, therefore I did not have formal approval and required consent processes in place for participant observation when I first undertook it. Having been through the process of gaining the approval of the ethics committee for the first stage of my project, I had an understanding of the standards of ethical research and therefore was able to take all reasonable steps to ensure adherence to them by gaining permission from the organisations' managers and staff, taking all reasonable steps to make all participants aware of my role and where possible, obtain oral consent for my participation in their activities.

The practical application of my ethics procedures also caused an unexpected problem. One of the service users at Healthy Millborough, a middle-aged lady of South-Asian origin, verbally agreed to be interviewed. When we sat down to do the interview she became very anxious and confused when I asked her to sign a consent form and declined signing it, I assume due to poor command of written English. Not wishing to cause any distress, I apologised and didn't continue with the interview, which overall is a loss to my project. With the benefit of hindsight, it would have been possible to proceed with recorded verbal consent which would have satisfied the criteria of ethical research.

3.6 Overview of fieldwork and collated data

With each case study a similar protocol of data collection was followed allowing for differences in organisational structure, types of services and external relationships. I consider the sample of respondents in each case was sufficient to access a broad range of opinions and viewpoints; combined with participant observation of activities the conducted interviews allowed insight into to all key areas of work for each organisation and access to (informally or through formal interview) most people involved in the day-to-day running of the organisations.

The organisation of fieldwork was planned to facilitate reflexivity with “rolling revisits” (Burawoy, 2003) allowing for a continuous cycle of simultaneous data collection and examination of emerging themes. Acquired knowledge was used to further focus data collection and in turn the new data was used for development of analytic interpretations of the data already collected:

> ‘"visits" to the field are viewed as a succession of experimental trials, each intervention separated from the next one to be sure, but each in conversation with the previous ones. In this conception, field work is a *rolling revisit*. Every entry into the field is followed not just by writing about what happened but also by an analysis in which questions are posed, hypotheses are formulated, and theory is elaborated-all to be checked out in successive visits. In this rendition, field notes are a continuous dialogue between observation and theory.’ (Burawoy, 2003: 668)

Drawing out the fieldwork in time highlighted the changing nature of organisational life, and allowed me to observe evolving strategies for improving organisational resilience and changing relationships with external stakeholders, providing new perspectives and adding to the depth of analysis:

> ‘Reflexive field work, in short, calls attention to realist as well as constructivist moments. It demands that the field be understood as always in flux, so that the rolling revisit records the processual dynamics of the site itself. But, more than that, the rolling revisit demands attention to disruptions of the field from outside, which shift its character and take it off in new directions. Still, remember that this field-in-flux can be grasped only through theoretical lenses and through the ethnographer's interactions with those he or she studies’ (Burawoy, 2003: 669)

Fieldwork in Health Connections and Healthy Millborough was carried out simultaneously. The organisations were first contacted by email and telephone in July 2011 and on agreement to participate in the research project I obtained some documentation pertaining to their work. Fieldwork was carried out during three 2-3 day visits to each area which took place in October and December 2011 and March 2012. The final visit to report research findings took place in November 2012. Although this wasn’t the initial intention, the research had a longitudinal aspect as fieldwork was carried out across a period of 13 months. This allowed for some changes within the organisations to be observed; projects evolved or finished, new ideas were

being implemented, new members of staff started employment and the general mood changed with changes in external circumstances. Therefore the data from these two case studies is not a "snapshot" at a point in time, but a series of interlinked illustrations of organisational life set in an unsettled policy environment.

The Overton Wellbeing Group case study was commenced after fieldwork was finished in the first two. This was due to organisational reasons, but also meant that it was informed by the previous fieldwork experience. It provided an alternative and supplementary view of an organisation that declined taking the route of hybridisation, yet was still dealing with the problems of sustainability and autonomy, and many common themes emerged. Participation was agreed with the organisation in April 2012 and fieldwork was carried out during several one-day visits over the course of May and June 2012. There was comparatively less data collected in this case study due to the smaller size and range of activities provided by this organisation. My relationship with the internal respondents was also different and by nature less demanding as I felt it was important to respect their time as volunteers and limitations caused by their personal circumstances.

In the early stages of fieldwork in each case focus was placed on external stakeholders who were interviewed in the role of key informants. Managers of the studied organisations were asked to indicate any important local partners they may have in carrying out their work as well as representatives of their funding bodies. The aim was to gather a range of opinions and external perspectives on how the organisations approach their health promotion role, to explore the potential significance of these relationships and gauge the impact external factors had on the organisations' work. The focus then moved to interviews with individuals who contribute directly to various aspects of the organisations' work. Finally interviews were carried out with representatives of the local community. These included people from the communities who work alongside the studied organisations in various capacities and their service users. These offered insight into the organisations' role in the local community.

Throughout the period of fieldwork I observed and participated in the work of the organisations. This included spending time in the organisations' offices, attending staff meetings and observing the work done in the community by front-line members of staff. The broad aim was to expand the knowledge and understanding of their work and approach gained through interviews with staff members and volunteers. Participating in activities led by staff members gave me the opportunity to build a relationship with research participants, ask question and seek information to better understand the specific circumstances of the services

in a more informal manner. When observation preceded interviews the respondents often made reference to the events I witnessed to explain certain points and I would also deliberately seek further clarification of events.

I established a good relationship with Health Connections and Healthy Millborough staff, therefore I decided to organise a “creative methods” workshop there (please see Appendix F for the workshop plan). I did not make use of this method with Overton Wellbeing Group as I felt the volunteers would not necessarily have the confidence to express themselves this way. At the beginning of the workshop participants were given a selection of magazines with pictures which would not relate in any direct way to their work and encouraged to think in a metaphorical and abstract fashion working collaboratively on a collage answering the questions “Who are we and what are our important qualities – for our partners, for individual service users and for the community as a whole?”. Participants were encouraged to reflect on their day-to-day practice – crystallise their thoughts, negotiate ideas and think of the bigger picture through a “facilitated form of talking” which would have minimum direct intervention from myself. They were left for about 30 minutes to carry out the task with a recording device in the room. Afterwards I asked them to present their piece and explain the meaning of particular images. The created artefacts were used only to “mediate” abstract concepts expressed by the participants and only the recorded verbal data was analysed. Photographs (below) were taken of the collages and retained to assist in the analysis of the workshop recording.

Figure 4: Healthy Millborough's collage (L) and Health Connections' collage (R)

I consider the data generated by this method as a valuable contribution to my understanding of the organisations. In Health Connections it inspired a fascinating discussion which provided crucial insights into some negative aspects of the organisation's hybridising habitus (see vignette in chapter 5.4). In Healthy Millborough the selected images and discussions during the creation of the collage highlighted staff members' feelings of uncertainty about the organisation's future and of powerlessness due to reliance on external recognition and financial support.

The tables below give details of the people and activities accessed in the course of fieldwork.

Table 3: Fieldwork overview - Health Connections

Method	Participants/Activity
8 internal interviews	3 trustees Project manager (2 interview sessions) Finance and administration manager 2 community health workers Social work student on placement
4 external stakeholder interviews	NHS Voluntary and Community Sector commissioner Social care commissioner GP practice manager Council for Voluntary Services health partnership manager
4 Service user/community member interviews	Youth Centre manager Local community enterprise employee Group interview with 4 participants of men's group Ante-natal support group user
Participant observation of 8 activities	2 social activity groups for the elderly/isolated 2 ante & post-natal support groups Sexual health and alcohol awareness outreach work Cook & eat session for people with mild mental health problems/suffering isolation Community networkers meeting Office work
Staff workshop	5 community health workers
Presentation of initial findings	Staff meeting: 9 members present Board meeting: 5 members present

Table 4: Fieldwork overview - Healthy Millborough

Method	Participants/Activity
11 internal interviews	4 trustees (of which 2 also in role of external stakeholder) Chief officer (2 interview sessions) Finance and administration manager Administrator 3 community health workers Food coop volunteer
4 external stakeholder interviews	NHS public health manager Council community assets manager Housing association director for regeneration Housing association community projects manager
3 service user/community member interviews	Group interview with 3 community gym users Community organiser Citizens' jury participant

Participant observation of 5 activities	Food-coop opening to customers Citizens' jury session on community pharmacy provision Consultation for NHS with local grassroots group Cook & eat session in substance misuse rehab programme Office work
Staff workshop	4 community health workers
Presentation of initial findings	Board meeting: 6 members present

Table 5: Fieldwork overview - Overton Wellbeing Group

Method	Participants/Activity
5 internal interviews	5 committee members, including the chair
2 external stakeholder interviews	NHS Health Trainer Voluntary Sector Liaison Manager for Health and Adult Social Care
Service user/community member interviews	Group interview with 3 exercise group participants
Participant observation of 4 activities	2 gentle exercise groups Social activity group Committee meeting

3.7 My role and experiences as researcher

The positioning of the researcher as an "insider" or "outsider" is significant in ethnographic research. I undoubtedly arrived at the organisations as an "outsider" being new to the locations and to community work and health promotion as areas of organisational activity. Participant observation however sometimes blurred this boundary. When attending structured activities with community members, such as cooking sessions or exercise groups, I would generally join in with other participants. On the other hand, in less structured settings such as the food-coop, ante- and post-natal drop-ins or social groups for the elderly I would volunteer to help out where I could, setting up, making tea, or preparing resources. Also when "hanging around" at the offices I tried to be helpful having a sense of obligation to "give something back" to the organisations. This was made the most of at Health Connections, where Patricia the manager would ask my opinion on matters and I was given small tasks to perform in the office. I do not feel that such involvement hampered my research efforts in any way, on the contrary, being included, even to a small degree, in the organisations' daily work provided valuable research experiences.

I think that a researcher engaging in an ethnographic study simultaneously embarks on two journeys: one that leads to learning about the ways of being, doing and thinking of the studied groups and individuals, and one that is directed inwards, towards discovering the researchers own identity, dispositions and preconceptions in contact with a new environment. Experiencing the new physical and social environments of "the North" and of a disadvantaged community in southern England felt very much like travelling to a foreign land, as having lived in the UK for four years I had previously mostly experienced the urban and suburban areas of southern England dominated by a middle class population. The post-industrial urban landscape and run-down estates that I encountered during my fieldwork couldn't be more different than the vibrant and well maintained urban centres or the peaceful and leafy suburbs and villages I was used to. On the other hand, I also had one unexpected experience of feeling "at home" in the landscape. One morning I arrived early for a meeting in Overton and took 30 minutes to stroll around the estate. Walking amongst the well-spaced low-rise and high-rise 1960's tower blocks I suddenly experienced an overwhelming and surreal sense of familiarity which strongly conflicted with the public perception and my own preconception of this estate as being an unsafe, unpleasant and unsightly place. I tried to understand this and realised that this landscape was very similar to the estate I grew up on in Poland. The key difference between the two is that in Poland such estates housed a broad range of social groups and did not carry the same social stigma as in the UK; it is not the physical environment itself that impedes the cultivation of bridging social relationships between areas (although undoubtedly it was not particularly attractive) but its socially constructed connotations.

I had a very contrasting experience in Millborough when for the very first time I walked to the community centre where Healthy Millborough was based. The route from the town centre took me down the main street of what, at first glance looked like a typical English neighbourhood of Victorian terraces. However if it wasn't for the neat rows of identical brick houses, I could have well been on the Indian sub-continent. There were several mosques which dominated the views down the side roads, the corner shop displayed fruit and vegetables that were entirely unidentifiable to me and, most poignantly, I didn't encounter a single other white person in the 15 minutes it took me to reach my destination, not during my first visit, nor on any of the other occasions I went there. I quickly realised I was being observed with interest and although it was in no way intimidating, it made me feel self-conscious. I had never anticipated that I could be so profoundly aware of my "whiteness" on a busy street in England. I mentioned this in a conversation I had with Kirsty, a young, petite and blond Healthy Millborough employee. In response she told me of a thought-provoking

observation – that although she sometimes walked through that neighbourhood on her own after locking up the community gym at 10pm, she never felt threatened or unsafe, whereas this was frequently the case when she would go to one of Millborough's white working-class estates in the middle of the day.

Travelling to my fieldwork destinations I became very aware of not just my ethnicity, but also of my middle-class, southern-England circumstances. Being someone who generally doesn't wear branded clothing I suddenly realised that even wearing a North Face raincoat made me stand out in the localities I visited and was somewhat out of place despite the cold, wet weather. Nevertheless a coat can be taken off when meeting interviewees and participating in the groups run by the community workers, but an accent cannot. I participated in a Cook and Eat session, I only managed to say two sentences introducing myself to the participants when one of them, a man of Afro-Caribbean origin with impressive dreadlocks, interrupted me and said 'wow, you sound posh' – not in a judgmental way, but just as an observation. All I could do was chuckle, explain that I sounded like that because I live in southern England, but really I'm Polish so how I speak doesn't really give away the whole story, and that did make everyone smile. I was generally quite aware that the people I met in the course of my fieldwork needed to "categorise" me to understand who I was and why I was there. I quickly learned that saying that I was Polish meant that I was then perceived more as an "outsider" (so not easily classified to any particular social group), allowing me to declare my ignorance and ask for explanations of how things worked and making respondents feel more confident.

In the course of research I was also confronted by my own prejudices. This was noticeably the case on two occasions: when I was participating in Healthy Millborough's Cook and Eat session with people in substance misuse rehab and in Health Connections' Friday night outreach work with young people. I found myself surprised by how approachable and amicable the participants were and realised that my expectations of what they would be like were based on stereotypical images. I contemplated this on a long train journey home when writing up field notes after a week at the study locations. Although I would have never thought of myself as someone influenced by stereotypes, having a very sheltered upbringing meant that I rarely had any first-hand experience with marginalised groups and all my preconceptions were based on societal attitudes and common stereotypes. That was very poignant learning for me personally and for my research: I gained a new, deeper understanding of the mechanism of social exclusion and how easily we make judgements about other people based on their belonging to a social category. This gave me important insight into the significance of the work carried out

by the organisations I was studying – reaching out over social barriers and approaching those who are socially disadvantaged with a positive and open-minded attitude, offering recognition, respect and an inclusive environment. I understood how that in itself created social value and promoted wellbeing in communities.

These trips were therefore personally enriching, providing me with an opportunity to critically examine my own identity as well as gaining insight into the life-world of a section of British society that was previously unknown to me, a completely "different England" then the stereotypical imagery of the prosperous South.

3.8 Research challenges

Conducting fieldwork for this research project was overall a very positive and enjoyable experience. I was coming as an outsider to my case-study organisations, yet I was made to feel welcome and trusted with considerable insight into the organisations' work from the very beginning. My presence as someone who "hangs around", asks lots of questions and takes notes was, I feel, fully accepted. The one question I had to answer many times was "Why have you come all this way to study us?" There was a certain disbelief that their organisation was doing something noteworthy and that there were not many other similar ones that I could go to.

In reality, identifying potential organisations which would fit the criteria of my research was a challenge. There aren't any comprehensive listings, the organisations are formally registered as different organisational types, or not registered at all, and it is difficult to find those that have general "health improvement" aims, not focused on a particular need or social category of service users. Also there was an increase of "healthy living" initiatives under the New Labour government which led to founding many organisations, however by the time I was searching in the spring of 2011, many have ceased to exist due to policy change and lack of funding. As was the case with Overton Wellbeing Group, many organisations work on a small local scale and have no online presence. "Google" was the main tool in my searching and found that some organisations were grouped in regional networks or some I found through websites of other organisations that support the third sector in delivering health services. Interestingly, from the organisations that I found there was a very uneven geographical distribution, with far more organisations working in northern England than in the South or Greater London. I did not wish to have a "representative" sample, however I was keen to learn about the experience of organisations working in different social and institutional contexts. Interestingly, in several organisations that I got in touch with I had some difficulties with obtaining a response to my

enquiry, as there was uncertainty as to who can make the decision and the managers were usually difficult to get hold of.

Effective project management was a significant challenge as my travel arrangements to the research sites meant I was in the research locations for a strictly limited period of time and with a tight schedule, so needed to prioritise meetings with respondents that were most valuable to the study (and usually were the ones with the busiest diaries), start setting dates several weeks in advance and communicate by email and telephone with people who are very difficult to get hold of. Due to scheduling problems and respondents dropping out at the last minute on my first trip I was unable to carry out all the interviews I had planned and I was invited to observe and participate in some of the organisations' activities in the community. I accepted these invitations as I felt it was a beneficial use of my time and was concerned that turning down such an offer could have had a detrimental impact on my relationship with the organisation's staff and their engagement in my research. As a consequence, carefully planned research stages and schedule were not followed; in my first few days in the field I was carrying out participant observation, which was initially planned for my second and third trip, to use the time that I had with the organisation effectively.

Recruiting my external respondents (stakeholders, service users) was generally a more difficult process than I had anticipated. I had a key contact person in each organisation who acted as my "gatekeeper". I was entirely dependent on them to recommend suitable respondents and to put me in touch with them. Although this was to some degree a limitation in the case of external stakeholders who would often consent to me contacting them directly, it was a particular constraint in the case of service users. All my communication with them was dependent on the organisations that also didn't necessarily have effective means of contacting them due to the informal nature of their relationships. As a result, I interviewed only a few service users and their sample was largely convenience-based. The interviews had to be organised in an ad hoc fashion after group sessions which meant I didn't necessarily have sufficient time for in-depth discussion.

3.9 Data analysis and interpretation

The research data consisted of verbatim transcriptions of recorded interviews and staff workshops and field notes; these were uploaded into the NVivo software package which was used to facilitate the process of systematic organising, categorising, annotating and retrieving of data. Data was analysed inductively, an approach which is integral to the ethnographic method, and analysis commenced during fieldwork when I noted recurring themes in

interviews, reflections relating to my observations, similarities and differences between organisations and relationships between emerging themes. This led me to refine my research questions after initial fieldwork visits, guiding further investigations in the field, and generated some of the key themes developed later in analysis, for example, “local path dependence”, “recognition”, “entrepreneurial spirit”, “focus on personal relationships” and “tensions between ways of working”. Similarly, transcribing interviews gave me considerable time to familiarise myself with the data and identify further emerging themes. Memos, a written record of my thought process regarding emerging codes and categories, were written throughout the research process. I have used them to for example, explore how codes related to each other in a particular context and to note potential hypotheses for further exploration. Memos therefore functioned not only as documentation of the analysis, but also helped define leads for further coding.

Brewer’s (2000: 109) steps of ethnographic data analysis provided direction for the systematic analysis process. Firstly, data was organised according to organisation to facilitate within-case analysis and cross-case analysis of the organisations. Then I commenced the procedure of thematic analysis described as ‘searching across a dataset (…) to find repeated patterns of meaning’ (Braun & Clarke, 2006: 86). This involves a cyclical process of reading through the data and coding. In the first phase I applied descriptive codes which did not necessarily fix meaning to the data, but allowed for more detailed organisation and retrieval of the content and constructing in-depth case descriptions. Then moving from description to analysis, I focused on identifying similarities and differences between cases, organising codes into themes and gaining a sense of which themes were particularly relevant to addressing my research questions. Following leads from the literature, the analytical themes of “sustainability” and “autonomy” were established. These themes were then reviewed and reworked until they adequately framed the data and provided a ‘coherent and internally consistent and account’ (Braun & Clarke, 2006: 92). The final list of codes is available in Appendix G. This was the point when the “story” of the organisations and their relationships started taking shape and I began the process of interpretation, i.e. bringing meaning and significance to the data and explaining the patterns, categories and relationships that exist between them. These initial findings and interpretations of data were presented to staff and trustees of Health Connections and Healthy Millborough and corroborated by them.

Theoretical interpretation of the patterns in the data was established through a dialogue between data and theory as I developed increasingly abstract theoretical categories. Relatively

early in the process I identified Bourdieu's notions of "field" and "habitus" as particularly useful conceptualisations of data and I recognised the explanatory power of Cultural Theory's categories of "grid" and "group" for unravelling the tensions associated with hybridisation. After considering how well it "fits" the data, Bourdieu's theory was chosen as an appropriate theoretical lens for making sense of the data. The discussion of findings in chapters 4, 5 and 6 of this thesis was therefore organised around the theoretical categories of "field", "habitus" and "capital". The last stage was making 'abstract generalisations' (Brewer, 2000: 149) basing on the data. I found the theorisation of the structural constraints faced by community health promotion organisations in the health field to be particularly compelling as it complements existing explanations of the challenges these organisations face in their attempts to remain sustainable and autonomous.

3.10 Organisation of research findings

This chapter has presented the methodology applied to gain understanding of how community health promotion organisations are managing in circumstances of marketisation and austerity. Each of the following three chapters examines a constellation of factors that were found to support or hinder organisational efforts to remain sustainable and autonomous, organised around Bourdieu's concepts of field, habitus and capital. Chapter 4 discusses the organisations' institutional context using field theory, exploring the relationships and "rules of the game" within local health fields and setting the scene for developing an understanding of the value of various forms of capital. Chapter 5 moves the focus to examining findings relating to organisational culture. Applying the lens of habitus facilitates analysis of the predispositions and beliefs of the people involved in organisations which define their "way of life" and drive their preferred ways of working. These are contrasted with the expectations inherent in their fields to present the complexity and challenges of a hybrid habitus which would incorporate ways of working from the public and private sectors. Chapter 6 considers the various forms of organisational capital which enable organisations to improve their positioning in the local health field, the key determinant of sustainability and autonomy. The three analysis chapters build an account of the tensions between the explicit and implicit expectations placed on the organisations by other actors in their local health systems and the willingness and capacity of the organisations to meet them, whilst also highlighting the significance of broader issues of power and social relations.

Chapter 4

Organisational positioning in the field: the influence of local context

The case study organisations are part of many fields, with their beliefs and attitudes firmly rooted in community development, but their working relationships predominantly in the health field and the third sector sub-field of public service delivery. This chapter will focus primarily on the local health field which incorporates the public sector, third sector and, increasingly, private sector organisations involved in providing a variety of health and wellbeing services. Funding for community health promotion organisation is distributed in this field, therefore here the stakes are the highest. Actors are dependent on a finite sum of public sector money, therefore their relationship is to some degree competitive, but they are also expected to collaborate to provide the best possible integrated services for the population served.

The central actors in local health fields are public sector agencies, predominantly the local authority and NHS budget holders, who act as the "incumbents" (Fligstein & McAdam, 2011). The case study organisations all started out as projects led by public sector agencies, however after becoming independent their relationship with them has taken different trajectories. Respondents emphasised that external circumstances were the main driver of change in the organisation in recent years and a key trigger for many strategic decisions, increasing uncertainty about future funding and, to some degree, limiting their autonomy in determining the organisations' future. Taking a field perspective acknowledges the interdependency between organisations and their institutional context and that 'organizations do not float in a neutral 'environment' but that their actions produce and reproduce the world that they inhabit' (Mutch et al., 2006: 608).

Bourdieu's theorisation of fields draws attention to the power relations that are implied in the positioning of actors. Community organisations are positioned on the periphery of the health field, they have relatively little or no power, and consequently are obliged to play along with the "rules of the game" that are established by other actors. In the course of my research it became obvious that organisations vary in their ability to act strategically to improve their positioning and gain some influence in the field. Similarly, some local fields are a more supportive environment for community health promotion than others. Austerity politics and

progressing marketization have been driven by central government thus setting the broader "rules of the game"; however the local policy actors are the ones that have significant influence over how these policies are translated into practice.

In this chapter I will discuss how the organisations are influenced by relations in their local health fields and how they perceive and respond to the changing "rules of the game" in their field. I will illustrate how three characteristics of the organisations' environment: the approach and procedures relating to distribution of resources, the quality of relationships with key stakeholders and the support of local third sector partnerships, affect their chances to remain sustainable and autonomous. Finally I will examine path-dependency of how relationships are formed in local health fields.

4.1 Stakes in the field and "rules of the game"

This section examines the dynamics of the local health fields the organisations work in, the "stakes" the organisations are competing for with others in the field and the explicit and implicit rules that govern these relationships. Firstly some consideration is required of the broader political and economic factors that shape these fields.

4.1.1 The political and economic climate

My respondents from all three organisations referred to the broader economic and political landscape indicating that their situation had been directly affected by the economic downturn and change of political agendas. Health Connection's NHS commissioner acknowledged that third sector organisations face very difficult circumstances:

> '*But a lot of third sector organisations they've had years and years of not getting any decent funding, last year they've had a decrease in funding, for some of them in two directions, they will get another reduction this year, it's like, how do you keep operating within that context? Even if you know you're brilliant. You wouldn't ask any business to do that. Even on the "Apprentice" they don't do that to the poor candidates.*' [James, Commissioner]

There is a strong sense of frustration in the organisations with the political rhetoric about the "Big Society" and concern that it gives public agencies the mandate to expect community groups to continue delivering services without any support, like was the case in Overton where the volunteers were no longer assisted by a council employee.

> '*I think the sad bit is that the Prime Minister says all of it about the Big Society, about how community groups are doing this and doing that, he's not got the real*

picture, he's got no idea really. (...) But the government for some obscure reason, it makes me so wild, they stand up there pronouncing about all these volunteers and they're doing all this for nothing, but you still need the funding there.' [Jill, Chair]

Additionally the organisations were witnessing the effects of public sector cuts on the communities they work with and perceive it is their role to try to mitigate their impact. Health Connections had observed a rise in referrals for people who need support in terms of their mental health since local social services toughened their referral criteria. Similarly Overton Wellbeing Group had more people interested in attending their social group for isolated people with mobility problems (they organise transport for those who need it) than they can accommodate in their available venue:

'*we've had referrals from social care for people to come along to the [social group] because they are closing the day-care, we are filling a very important gap. (...) we are providing something that the state is more or less ignoring, they're saying – oh well. I think they're sitting back letting the volunteers pick up, fill this gap.*' [Jill, Chair]

Healthy Millborough had been particularly badly affected by public sector cuts, something that took Rashid their manager by surprise. He subsequently recognised that the organisation was too dependent on grant funding and did not have the resilience to overcome a sudden loss of income from the PCT.

'*I wasn't expecting 3 years down the line to be in such a bust type of environment, we were having a boom, now we are having a bust, aren't we, I wasn't expecting it to be so severe, the public sector spending cut, because obviously, we were heavily reliant on that*' [Rashid, Chief officer]

The organisation went through a difficult period when both the management team and staff members were very conscious that their sustainability is critically threatened - staffing levels were cut back and remaining employees reduced their hours or took a pay cut to balance the budget. This had very much focused the organisation on financial issues – both on ways of gaining new funds and altering their way they work to make savings.

My respondents also perceived the commissioners' expectations regarding the resources needed for the organisations to continue delivering services to be unrealistic. Overton Wellbeing Group, despite being small and volunteer-run, still needed a small budget primarily

to pay instructors that ran their exercise groups and to cover the cost of using some venues. Equally the two larger organisations admitted that they found it difficult to raise funds to cover their core costs such as maintaining office support and paying management salaries as the majority of money they received through public sector contracts had strict stipulations restricting them to budgets for closely specified projects:

> '*The biggest thing for charities in relationship to commissioning is core costs, there are very few funders who give us core costs. There are very few commissioners who will agree for management fees. So where can we find core costs for our organisations? Very hard*.' [Rashid, Chief officer]

They believed that funders were assuming that third sector organisations would independently raise some of the funds necessary to keep services going. The restrictions in the funds made available for third sector organisations by public sector agencies were the key reason for the two larger organisations in my study taking on new ways of working to meet commissioning requirements and make themselves less reliant on public sector grants. This is highly problematic, as will be further discussed in the following two chapters, as finding ways of generating income places a significant burden on the organisational resources, and assumes that the organisations have the capital to do it in the first place. Overton Wellbeing Group had very limited means of significantly increasing their income, however Health Connections and Healthy Millborough had been focusing on generating funding independently of public sector grants which had prompted the organisations to introduce more business-like ways of working:

> '*it's critical to our sustainability to look at diversifying our funding base, so look at not just grant funding, although we are looking at other sources of grant funding, but also looking at individuals, corporate, events, legacies, anything we can to actually bring in more income so that we are less reliant on one source of income. It's absolutely critical to our future*.' [Kate, Trustee]

Scarcity of available financial resources has forced all three organisations to adapt their ways of working to accommodate a smaller number of staff or to better match the expectations of funders (more details and discussion in the following chapters), which to some extent has led to compromises in their autonomy.

Health Connections' funding: a 2015 postscript

In July 2015 I accessed Health Connections' website in order to obtain some figures from their annual report. On their website I found a message asking for urgent support for the organisation – both financial and through signing a petition to their local authority. Health Connections have been receiving 35% of its income in the 2014/2015 financial year from their local authority public health budget, however in June 2015 the council had decided to withdraw all of Health Connections' funding due to central government cuts. This succeeded a recent announcement from the chancellor that the Treasury will be cutting the local government public health budget, which was ring-fenced by the previous Coalition Government, by 7%. The council had previously suggested that it would only provide further funding for the organisation's work if it concentrated on specific groups in other parts of the district where they perceived the needs to be greater. Interestingly, Helen who worked at the local CVS had mentioned to me before that Health Connections works in an area where the needs are overlooked by the authorities.

'*[Town] is a funny area because it has its pockets of deprivation, but in terms of [district] it is generally slightly more affluent. It certainly doesn't have the diversity of different cultures that the inner city has, so it gets forgotten sometimes.*' [Helen, Health Partnership manager]

Health Connections recognises this, but also sees that people living in the disadvantaged neighbourhoods of their area are particularly socially isolated. The organisation therefore uses the social resources available locally to enhance its services, for example through recruiting a broad pool of volunteers. The council assessment of the needs of the area

4.1.2 Access to public funding

The organisations' positioning in the local health system was thought to be undermined by the growing level of competition for funding amongst local agencies. This trend was perceived to apply to both large-scale contracts and small grants such as the one Overton Wellbeing Group use for their funding, even by groups who are not necessarily working in the health field:

> '*word has got round [about the participatory budget], and I think also there has been a lot of cutbacks in funding as well, because we've had a lot of bids in this year, it was obviously from groups which were going to go for it, regardless.*' [Jill, Chair]

Many of my respondents remarked that their field is becoming more crowded as a result of the scarcity of public funding with many organisations expanding the scope of their work to be able to access a wider range of funding sources:

> '*What's happening in this borough is probably happening elsewhere, is what 2 years ago I wouldn't have seen as organisations I compete with, have now become major competitors. Because they're diversifying, they're expanding what they do because they need to bring in the money*.' [Rashid, Chief officer]

Janet who coordinated community initiatives for a Millborugh housing association observed a recent increase in the number of parties interested in collaborating on projects which she found may have a negative influence their effectiveness:

> '*more partners are wanting to come round the table, sometimes partners who really may not necessarily be required to be there, but if there is the potential of a slight sniff of money coming along, then they feel that they've got to be there, so that's sometimes just changed the dynamics if people are actually looking just for funding rather than looking to resolve an issue.'* [Janet, Housing association community projects manager]

The organisations were also responding to government policy of opening of service provision to "any willing provider"[5] (House of Commons Bill, 2011) and finding that they are increasingly having to position themselves against bigger organisations who are competing for the same funds. Several of my respondents expressed concern that public sector agencies, intentionally or not, favour large organisations:

> '*for somebody like the PCT to go to a charity or to a social enterprise rather than to one of the larger providers would be fairly uncommon because they tend not to have the same faith in smaller organisations and charities that they would do to one of the larger healthcare providers.*' [Janet, Housing association community projects manager]

It was suggested to me by respondents in both Health Connections and Healthy Millborough that these "hoops" to jump through to receive public money are deliberately set up to ensure that the organisation has the right capital resources at the outset to make it a "safe" investment. Firstly the organisations need to have the

[5] Now referred to as "any qualified provider"

capacity, both in term of time and skills, to put together funding bids and be able to "tick all the boxes" in the bureaucratic process:

> '*But when it comes to council tendering, it's the same staff that puts the grit on the road, same tendering process. So they will have 5 points and if you haven't got them, that's it, you're out. (…) Whereas the big organisations, the Tesco's the Sainsbury's, Serco, Capita, they will have people who spend their days just learning to do that*' [James, Commissioner]

Secondly, organisation's existing financial resources and track record of managing large budgets have been a key criterion. Even though Health Connections were a relatively large and influential organisation locally, they had just lost in a community health promotion tender to a large organisation based in a different region of England. This had motivated them to start looking for partner organisations who deliver similar services in the local area to form a consortium for joint funding bids to be able to increase their operational capacity. Existing capital and capacity allowed for increasing an organisations' chance to increase its funding. The smaller, less "professional" an organisation is, the more difficult it will be for it to remain sustainable - this pattern is clearly visible when comparing the three case study organisations. This argument will be further developed in subsequent parts of this thesis.

4.1.3 Health priorities and service design

The organisations were also competing in the health field for a second type of "stakes": the dominant vision of local health needs and how they are to be met. Emma who used to manage the council team responsible for community work in Overton expressed a widely held sentiment – that prevention and community development remain a marginal area of activity for statutory organisations, in spite of recommendations made, for example, in the Marmot Review (Marmot, 2010) regarding applying community interventions to decrease health inequalities:

> '*Yeah, well I think investing in prevention has been, every paper that whatever government has commissioned as far back as the 60's, all leads to, it's better to spend money in prevention and communities, it's key, everything says so, but by the time it comes to the ground, it's never happened yet. (...) This government particularly, with Big Society that's what they're saying, but you know, it's all very well saying it, but they've cut all the staff, the council has lost loads of staff and it's not a statutory area, community development and working with communities, no.*

(…) with all the cuts and austerity measures, that's the area that is being cut. It's all short term, not long term investment.' [Emma, Local authority VCS liaison officer]

The health field is strongly shaped by commissioners from local NHS bodies and local authorities; these are middle level managers with the responsibility of translating national and local policy priorities into specific programmes and services. They establish the local "rules of the game" – the process for distributing funding, the target populations for community health interventions, the desired outcomes and often, ways of achieving them. My respondents in Millborough indicated that the local director for public health was very supportive of community-centred prevention and considers prevention as a priority area for spending, however in practice the resources made available for it were scarce and it was believed this was affected by other decision makers and bureaucratic processes:

'the prevention budget they've [the council] *got, £50 million sounds a lot, it won't go very far. And the director of public health is saying let's invest it, we'll save it in the future, but they're too short-sighted to see that. They want to fix their problems now with their sticky plasters. Short term solutions to long term problems, you know.'* [Rashid, Chief officer]

Overall, there was doubt and mistrust amongst my respondents of the public sector decision-makers' competence to commission services that would be innovative and would implement effective prevention. Emma who has an insider's view of the work of Overton' s local authority observed that despite there being interest in commissioning innovative services, the system tends to replicate existing ones

'But what tends to happen is the same old agendas end up taking over and the statutory things, and the same old people and the same old culture, so the idea of the framework it starts off sounding good, but ends up being exactly the same.' [Emma, Local authority VCS liaison officer]

Agenda setting for commissioning bodies is therefore highly contested ground where broader policy aims need to be incorporated and multiple groups are trying to bring forward the interests of groups they represent. In all three locations my respondents commented on a lack of correspondence between how they perceive the needs of the communities and the priorities set by commissioners. It was strongly felt by many community workers that their

knowledge and insights were being disregarded even though as practitioners they were more familiar with the communities than office based bureaucrats:

> '*They don't even know where [neighbourhood] is. They don't know what it looks like. They're writing a service spec to improve that neighbourhood's health. They don't even know anything about it. Do you know what I mean. (…) And a person will decide sat in an office with his or her limited knowledge of that issue, of that community, so it's very frustrating*.' [Rashid, Chief officer]

However Janet who collaborated with Healthy Millborough observed that to some extent government health policy drives local priorities which will be funded at a given point in time and the organisations have to propose corresponding projects to get funding:

> '*Yeah, if the flavour of the month is smoking cessation and there are lots of pots of money for smoking cessation, then undoubtedly that is something that they would have to focus on'* [Janet, Housing association community projects manager]

With community development as their preferred approach to health promotion, the organisations are increasingly compelled to deliver what is deemed effective by their commissioners, not what they believe is a valuable intervention:

> '*We can't, I can't survive just as an engagement organisation, because engagement, if you like it or not, is a luxury for statutory organisations. They don't have to always engage.*' [Rashid, Chief officer]

According to James, Health Connections' interim commissioner, historically the PCT's relationship with community organisations was 'messy' and largely 'about little agreements' drawn up as "pet projects" of particular individuals in the PCT, funded from many different pots of money and not monitored very closely, which gave organisations much more freedom in designing services. Current circumstances had forced commissioners to review and firm up their relationships to be able to substantiate funding decisions. James explained that the PCT therefore wanted the funded organisations to generate "outcomes" – specific and measurable changes, not "stories" about how individual lives have been transformed.

Health Connections and Healthy Millborough were finding that the stipulations associated with their current funding arrangements were constraining in terms of fulfilling their organisational goals and limiting their flexibility in adapting to changing needs, therefore potentially affecting their autonomy, as explained by one of Health Connections' trustees:

'*it comes down to money, what we can apportion funds to is restrained, and sometimes we see a need, we really want to address that need, but its slightly out of our post-code area or we can't quite align it to one of our, you know it's a constant process of trying to fit what we can spend the money on and what we have to report on with the need. (…) Rather than, let just move some money onto it and meet that need*.' [Kate, Trustee]

The organisations often have fixed targets assigned to their funding, and when I visited Health Connections for the final time their manager Patricia was in the process of negotiating a new contract for the delivery of a programme of physical activity and cooking sessions with their NHS commissioner. She was challenging the targets that their commissioner was setting for the project which were associated with the amount of weight lost by course participants, not in terms of improved wellbeing or long-term lifestyle changes which the organisation viewed as the ultimate goals of their work. This kind of discord had led Health Connections and Healthy Millborough to either compromise in some cases on their community development ethos and preferred ways of working, put in extra work to achieve both externally set objectives and their own aims or "dress up" their work so it appears as more appealing to their external stakeholders:

'*they're very beholden to the PCT, they get most of their funding from the PCT so their independence can be compromised by that. (…) the PCT sets their wider framework that they have to work in, so the name of the game, isn't it? So Health Connections interpret that and will probably bend things as much as they can, but are restricted by the PCT*' [Mike, Community centre manager]

The health field and relationships with commissioners were perceived as quite "rigid" and they did not necessarily take into account an organisations' mission, particular area of expertise or capabilities. This is the origin of hybridisation – organisations being compelled to work according to principles which are alien to them in order to maintain a position in the health field.

4.1.4 Reform

Fieldwork for this project was conducted in late 2011 and early 2012 - the lead up to the reorganisation of local health funding and the establishment of GP clinical commissioning groups. Changes to commissioning instigated the emergence of a new power structure and with it the uncertainty and speculation about how those changes were going to affect

voluntary organisations. The sentiment was however broadly pessimistic with fears that the GPs will be more difficult to lobby for community organisations then the PCTs were, and therefore have a much narrower view of the services and providers available. This is how Gerald, the director of the Millborough CVS and trustee at Healthy Millborough, commented on this:

> '*I think that with Healthy Millborough and the wider voluntary sector I suppose I think getting into clinical commissioning groups is going to be fundamental when it does happen and I think, yeah, just changing from a professional commissioner you're just changing the relationship to a GP (…), we're going to have to go with the hard sell of this is what the voluntary sector can offer, don't forget us, shout loud, and trying to do that with GPs is going to be, it's just a different battle*
> [Gerald, Trustee]

Particularly in Health Connections, which at the time of study most dependent on NHS funds, there was concern over the '*McDonaldisation of community health*' [Kate, Trustee] where a one-size-fits-all approach would be taken across the commissioned area and the distinctive needs of people in different localities would not be taken into account. Therefore despite their positive experience with collaborating with several local GP surgeries, respondents from Health Connections were sceptical about the direction of changes in commissioning and health policy in general:

> *'I really, really fear that it is going to become a more and more commercial endeavour which means volume, cheapness, focusing on waiting lists in hospitals rather than preventative stuff, because you can't quantify it or it's not very glam, it doesn't get the attention.*' [Kate, Trustee]

It was anticipated that the commissioning process would become increasingly focused on meeting formal criteria such as the organisation's turnover and not considering the organisation's more intangible assets:

> *'My biggest anxiety is that as we edge nearer and nearer to the clinical commissioning groups they will want the easy life of how they can commission certain things so there will be big tenders that go out, those big tenders, probably about 80% of how they make their decision will be about the income, so as an organisation we are quite a middle-sized organisation but we're not big enough to go for one of those tenders.'* [Patricia, Manager]

Consequently, many of my respondents spoke of the need to "level the playing field" in commissioning so that the organisations' local knowledge and established relationships in the communities are formally recognised and can be credited to them in the competition for resources:

> *'I think there needs to be something where, when tenders are going out, there is a weighting system for scoring when it comes to locally based organisations. Because it's great saying third sector, but you got third sectors who are multimillion pound national companies to ones like us, or people smaller than us. (…) So let's give us a just a little bit of a head start, give us that little bit of extra weighting on scoring for being local'* [Rashid, Chief officer]

The staff in community health promotion organisations feel aggrieved that the social and cultural capital that they do have, and that is valuable in working with disadvantaged communities, is unrecognized in the health field where the "rules of the game" established by commissioners place particular value on financial resources and bureaucratic competency. Anxiety about their sustainability in an austere environment and increased contractual regulation by public funding bodies were therefore, to some extent, drawing the two larger organisations' attention away from fulfilling their missions and undermining their autonomy. The process is explicit but also to some degree implicit with professional cultures and practices from the public sector 'transforming organisational meanings and perceptions of successful work' and with governance structures inflicting 'receptivity to policy instruments and their underlying logics' (Milbourne & Cushman, 2015: 469). These rules of the game shape the habitus and practice of community organisations which rely on inclusion in the field for funding. On the contrary, Overton Wellbeing Group remained close to a traditional third sector model and its ways of working were only marginally affected by external changes. Their sustainability however was threatened without the support of an external agency.

I found that the case study organisations see their political and institutional environment as volatile and unfavourable to their community-orientated habitus and preferred ways of working. Reflexivity i.e. a constant re-evaluation of their identity and position in the health field, is one of the "rules of the game" that the organisations have to play along with. The two larger organisations therefore perceived organisational hybridity, i.e. adjusting their ways of working to the expectations of the funders, as a necessary strategy in "playing the game" in the field and being able to continue their work in a marketised and bureaucratised environment. There was a strong sense amongst the people I spoke to that the size of

community organisations and their position on the periphery of the institutional health field put them at a significant disadvantage when competing for a decreasing pool of public funds and for influence over what the local priorities and "rules of the game" are.

4.2 Challengers in the field: negotiating relationships of power

The issue of power in the local health fields was often raised by my respondents. As indicated by Bourdieu and Wacquant (1992) relationships of power embedded in capital determine the structure of a field. Power is held by those that have access to the valued forms of capital and hence can pursue their interest, determine who enters the field and the positioning of others. The health field is quite hierarchical and highly professionalised with doctors and managers controlling the allocation of financial resources as well as determining how health issues are defined and addressed by local institutions – they are the "incumbents":

> 'the purposes of the field are shaped to their interests, the positions in the field are defined by their claims on the lion's share of the resources in the field, the rules tend to favor them, and shared meanings tend to legitimate and support their privileged position within the field.' (Fligstein & McAdam, 2011: 5-6)

Community organisations have a very different position in the social structure and the lay background of the staff means that their aims and ways of working may be marginalised and their interests not represented. I found an acceptance that community-centred health promotion organisations cannot be entirely "independent" in pursuing their goals and need to "play along" as explained by Fligstein and McAdam:

> 'most of the time challengers can be expected to conform to the prevailing order. They may do so grudgingly, taking what the system gives them and awaiting new opportunities to challenge the structure and logic of the system.' (2011: 6)

They seek to form relationships with local NHS organisations and local authority services which would support them in delivering effective services. My research has found however that these organisations have a decreasing ability to negotiate the extent and terms of the interdependence between them and their stakeholders. The general perception was that the relationships were very unequal with community organisations compelled to play according to the "rules of the game" set by others as illustrated above. In this section I will portray some of the organisations' strengths as perceived by their stakeholders, try to explain some of the barriers in the field and why the organisations may be perceived as "challengers" by others in

the field. I will also illustrate how they are trying to strategically position themselves and how this affects their sustainability and autonomy.

I interviewed external stakeholders who all had established successful collaboration with each of the case study organisations. They recognised that community organisations have particular advantages in accessing "hard to reach groups", one of the benefits of involving lay people in public health roles recognised in the NIHR 'People in Public Health' study (South et al., 2010). Stacey, herself a former volunteer in Overton Wellbeing Group, is from a disadvantaged background and credited the organisation with giving her the skills and confidence to move on to a paid position in the NHS – she worked as a health trainer in the Overton area. She told me other health trainers working in the city envy the community links she had built through Overton Wellbeing Group and that this mutual support benefits her service users:

> '*we work together and help each other out, if I could do anything for Overton Wellbeing Group, I would do it, and same with me, Overton Wellbeing Group would promote me'*. [Stacey, Health trainer]

She particularly appreciated being able to refer her clients to free exercise groups and having a support base in the volunteers, which allowed her to achieve better results in her work. This was an interesting example of someone working for the local NHS whose aims were very similar to those of Overton Wellbeing Group and who acknowledged that collaboration is highly advantageous even with her existing institutional backing. Having limited cultural capital in the form of qualifications or expertise, she was able to appreciate that providing mutual support allowed both sides to gain a bit more recognition amongst other actors in the health field.

The commissioners that I spoke to highlighted the benefits of community organisations providing services: their ability to work effectively and implement long-term programmes with disadvantaged populations and the perceived value-for-money of their services. James who commissioned services from Health Connections spoke of the financial benefits associated with commissioning services from third sector organisations:

> '*It's incredibly cheap to get the VCS to do something and your outputs will be much, on the whole, better*.' [James, Commissioner]

He argued that community organisations can successfully engage with groups that *'cost the NHS a fortune'* therefore hopefully reducing future costs of the NHS. Julia, a practice manager, spoke of similar benefits seen by her GP practice where referring patients to Health

Connections' social groups and befriending service has reduced the number of visits to the GP by socially isolated individuals:

> '*It's about wellbeing, and if somebody doesn't care enough to look after themselves, then they will constantly be at the doctors, they will constantly be admitted to emergency rooms because they need some kind of support, and it isn't necessarily health support that they need, (…) they may need social interventions.'*
> [Julia, GP practice manager]

Her practice supported community organisations in the belief that they can provide cost-effective services that fill a gap in the local health system and consequently reduce the pressure on NHS primary care organisations. One of Healthy Millborough's funding partners was the town's largest social landlord who gave them a grant to set-up of a food coop on one of the estates. They particularly valued the community-building approach taken by the organisation and the long-term and self-sustaining aspects of the initiative:

> '*The model that Healthy Millborough are trying to put together is that local people end up managing that, which is great for us, because we know that we've only got a commitment for 12 months, 2 years, and then it should be self-sustaining.*'
> [David, Trustee]

David, a director at the housing association, considered there to be a *'business case'* for setting up the food coop as they believed that it would not only improve residents' health, but also increase community cohesion and employability, therefore potentially improving their revenue stream. These examples demonstrate that community health promotion organisations have particular fortes which are considered valuable by external stakeholders. They can benefit other organisations both financially and organisationally serving as intermediaries between larger institutions and communities. This should give them some bargaining power in the health field, however despite offering specific skills and "value for money" they often still struggled to achieve the necessary support from key players.

The difficulties the studied organisations have experienced in gaining public sector funding and collaboration indicate that there are still other important problems for them to overcome. Firstly, their work is not valued highly enough by potential partners due to a lack of recognition of their approach to health improvement and methods of working (which translates to a lack of symbolic capital). Their community development ethos and holistic approach to health improvement can make them seem incompatible with the work of "mainstream" public sector

agencies. Secondly, there is a lack of trust in third sector organisations' "professionalism" and ability to deliver a good enough standard of service, both of which I will discuss later in the thesis. Community organisations however often require collaboration, buy-in or input from other agencies and individual health professionals to be able to carry out their projects and my respondents across all three organisations agreed that these relationships have often been problematic. The organisations experienced these barriers most directly when they were setting up a new service and needed to establish collaboration with GP practices, nurses or schools to gain access to potential service users. It was a source of frustration and gave the organisations a sense of being "kept out" of the field. Some of my respondents believed that these problems were rooted in a fear of external scrutiny:

> '*It's very difficult to get into the schools in Overton (…) it's very, very difficult that the schools don't want to have you in there, which doesn't really make much sense, but for some reason they don't want us there, they are not very enthusiastic, whether they don't want a bunch of volunteers coming along to interfere, who knows.*' [Jill, Chair]

The obstacles were even greater when they were trying to be a vehicle of positive change within existing services which raised anxiety about them trying to alter the way others worked. This is how Healthy Millborough's manager spoke of his experience of working on a project with school nurses:

> '*But I can get more people to see your services [school nurses], but in return you may have to change how you deliver your services, so then you get the clients you want. And that was the challenging bit because some people thought their service didn't need changing.'* [Rashid, Chief officer]

Chandra was leading a project which aspired to increase cancer screening rates among South Asian women in Millborough, focusing largely on community involvement. As part of the project she was intending to trial modifying the way the GP surgeries communicated with women invited for screening tests and was powerless in the face of strong opposition from one GP practice:

> '*We had a lot of people who were quite upset through the process [of reviewing practices associated with female cancer screening], because you're highlighting faults, highlighting what doesn't work (...) all we can do is report it, report it to the [funding organisation] because they've commissioned us, saying look, this is one of*

the GPs in that ward, they've refused to work with us.' [Chandra, Community health worker]

In the course of my fieldwork a common theme emerged across all 3 organisations – the sense that their work was appreciated more elsewhere than by other actors in their local health field:

'*So maybe they don't know what they've got that other towns haven't, that's my view, if the local authority and the PCT said about us the same things that people from other boroughs are saying, than I'd be the most resourced charity ever. (…) So when I talk to the Cancer Network for [region] or [local university] or [nearby local authority] with which I do some work, they think – wow – you do some great stuff here. But you know, Millborough – nah*.' [Rashid, Chief officer]

Emma who was involved in setting up the NDC project in the Overton area and was managing other community projects for the city council made a similar observation about the recognition Overton Wellbeing Group has received in a national community health initiative study, and their difficulty in gaining local support:

'*there has been a lot of interest in them, mostly from afar, locally, it's been tough for them. Local obstacles put in your way, if you want an excuse to not carry on, there is one every day, even in their own community.*' [Emma, Local authority VCS liaison officer]

This suggests that some of the organisations working in the same local field as my case study organisations may have been trying to marginalise them for strategic reasons.

It was widely acknowledged in my conversations with people both inside and outside of my studied organisations that other organisations often perceived them as disruptive and threatening. They were placed in the role of "challengers" (Fligstein & McAdam, 2011) in the health system, those who raise questions and want to change the status quo. Health Connections and Healthy Millborough, who often deal directly with the key players in the field, confirmed that driving improvements in the local health services is part of their mission, however they largely accepted that this may have been causing them problems and tried to mitigate this by building positive, collaborative partnerships:

'*I think there are always going to be some tensions in that relationship, because we are always going to challenge back if we see a process or a priority that, or a gap,*

> *you know something that isn't working in the favour of the people, you see we're always going to challenge back, but we also recognise that our job is not solely to antagonise the authorities, it's to work as partners with them, so we try to maintain a good working relationship.'* [Kate, Trustee]

Trying to identify the roots of these tensions between organisations directed my attention to the professional beliefs and practices which differ significantly between health professionals and community organisations:

> '*Because people are very precious and I suppose we would be very precious around how you engage communities and we have a sense of you don't dictate how you should behave in a community setting (…). Whereas a health professional has how things should be done with regards to telling people how they should or shouldn't behave. So there is a real clash of culture and it's about how we work softly without offending each other. (…) But it does take so much time! And motivation, because if the other side aren't interested, you can't do it.'* [Patricia, Manager]

The challenges organisations face when trying to gain "room" (Macmillan, 2011) in the field appear to be rooted in the "incumbent's" (explicit and implicit) institutional prejudices and anxieties, professional mistrust and fear of losing their position. Community organisations are campaigning for the recognition of their strengths and forms of capital which are particular to them in the health field.

> 'Indeed, much of the contestation in which organizations take part can be said to concern the legitimate valuation that is to be accorded the precise species of capital in which they happen (actually or potentially) to be well-endowed.' (Emirbayer & Johnson, 2008: 11)

They are however trying to challenge a well-established system of beliefs and practices. Every field has its "nomos": shared rules and a fundamental orientation which are 'not explicit or codified' (Bourdieu & Wacquant, 1992: 98). It acts as guiding principles to those involved, is common to its existing and new participants, but is distinctive from that of other social realms, therefore socially constructing boundaries between groups, for example professions (Atkinson, 2010: 9). Doxa, a socially legitimized belief in these conventions, is a subconsciously acquired way of thinking about the world (Lizardo, 2004: 388). Bourdieu uses the phrase "doxic acceptance of the world" to describe faith in 'a whole range of postulates, axioms which go without saying' (Bourdieu & Wacquant, 1992: 168) which are inherent to the social world one

is born into. Involvement in a given field is legitimised by “illusio” which designates interest, investment in and active engagement with the nomos. It is based on the acknowledgement that the stakes in the field are not only valid, but also ‘important … and worth pursuing’ (Bourdieu & Wacquant, 1992: 116). The socializing effect of the nomos explains the high degree of similarity in the predispositions and motivating structures (habitus) of people which have similar positioning in a field and the divergence between those who don’t. The community organisations were therefore often challenging the “comfortable” status quo in the health field when they were “let into” the field.

Negotiating the power relationships in their fields is key to community health promotion organisations’ autonomy and sustainability, and the three organisations varied considerably in their positioning and influence. Health Connections had been positioning itself as a local third sector leader through building relationships with other voluntary organisations and particular public sector agencies. With the support of the local voluntary sector infrastructure body they had organised a variety of events for other health-related organisations to discuss needs and gaps in local provision and to build partnerships for addressing them. Together with the good relationship with several GP practices, this had given them a relatively strong position locally which they had begun to take advantage of to influence local agendas and find new sources of income. Healthy Millborough had taken on the role of an aspiring lobbyist. Their current funding was primarily based on a lottery grant and several small projects funded by two local agencies which the organisation had long-standing links with. The competition locally for public sector funds was perceived to be very strong and my respondents believed that bureaucratic processes were putting the organisation at a disadvantage. As the only third sector organisation in town which delivered health promotion through community development they felt particularly undervalued by public sector agencies in their borough. Rashid, their manager, continued to lobby various local decision-makers to put community health promotion on their agenda and remind them of his organisation’s successful projects. He also aspired to grow the organisation to provide services in other towns where he felt their work was better received. Overton Wellbeing Group’s situation can be described as small-scale independence. Their income came from a grant that was awarded through a participatory budgeting process out of a community fund set up through the NDC scheme, therefore they were financially independent from public sector agencies. They were largely isolated from their local health field which on one hand gave them relative stability, on the other meant that in the long term, when their grant ran out, the organisation could struggle to sustain its work.

The three organisations were on the periphery of their local health field and have all experienced some form of marginalisation, but differed in how much influence they had in the local health field. Their ambition was to not only improve the health of individuals, but also to fulfil the greater aim of community development work – to empower communities i.e. influence local power structures (Bridgen, 2004). Achieving this however requires having some influence in the field which entails appropriate capital resources, often in the form of support from more powerful stakeholders. Their ability to deliver services according to their mission and perception of needs was hindered by the more influential actors in the field who did not give them the "room" to act. Instead they were often in the position of "challengers" in the field due to not being attuned with the more individualised and medicalised approach to health improvement taken by the actors in positions of power. In the next section of the chapter I will explore the key strategy employed by the organisations to improve their positioning in their fields – building strategic "coalitions" with other agencies. This reflects the organisations' ability to use their existing capacity, social and cultural capital to gain more capital, improve their positioning in the field and try to change priorities and the "rules of the game" in the field.

4.3 Building strategic coalitions: support infrastructure and established networks

The three case-study organisations differed in positioning and power in their local health field which reflected differences in organisational capacity and capital resources, was also considerably influenced by the quality of relationships between organisations locally. The availability of a support infrastructure for third sector organisations and/or an established network of like-minded community organisations gave organisations a valuable boost in the field. All three had recognised the value of establishing strong collaborative relationships with other local third sector organisations and were served by a local voluntary sector infrastructure body (CVS). The organisations differed however in their ability to achieve this, both as a result of differences in organisational capacity and the level of support available in the three locations. During fieldwork I noted a significant difference between how respondents from the three localities spoke of relationships between local third sector organisations; it can be presumed that some fields generate a more collaborative habitus than others, accounting for some of this variation.

CVS Health Partnership

Health Connections benefited from the work of a small team (which was funded by the NHS) based at their local CVS whose role was to build relationships between statutory bodies and voluntary sector organisations which deliver health-related projects. They advocated for the voluntary sector in strategic NHS and council meetings and could help organisations understand the expectations of statutory organisations. Helen who was part of this team told me about several successful initiatives which have helped Health Connections and other local organisations:

'*one of the things we recently did is, I say recently, it probably took 18 months but recently has come to fruition is around intermediate care and some money, that was, it being put out to help people coming out of hospital, (…) our proposal was accepted and that money was ring-fenced and is now going out to tender to the voluntary sector, so some of that money is now secured for the voluntary sector to provide services*.' [Helen, Health Partnership manager]

She also spoke of the benefits of being able to act as an "insider" in the field and having access to decision-makers and fund-holders:

'*And because we are funded by the PCT we get to use that to actually get in to, sometimes push things further. (...) so we are doing quite a lot of work with GPs, so a big piece of work that we are doing at the minute, which has taken a long time to get in, that is we go and train GPs in the surgeries about how to use the voluntary sector*.' [Helen, Health Partnership manager]

The local CVS had also organised a local Health and Wellbeing Forum where Patricia took on the role of chair. Consequently, she was elected to be a sector representative on the Health and Wellbeing board forming in the district.

It is suggested that one key aspect of "capacity building" is 'adjusting the institutional context' (Peltenburg et al. 2000 in: Cairns et al., 2005: 874), and this is clearly an important task which can be undertaken by third sector infrastructure bodies. Thanks to the CVS team who worked as a "broker" for third sector organisations in Health Connections' locality, community organisations were increasingly recognised as valuable partners by health professionals and commissioners in the district. Furthermore, some of my respondents observed that there was a long-standing positive relationship between the local council and the voluntary sector in the

area. Consequently Health Connections could pursue its ambition of building a coalition of local organisations strong enough to influence the agendas set by public agencies responsible for health locally. They had been given a small grant from the council to establish collaboration between local voluntary groups and to jointly provide a community-level assessment of health needs and gaps in provision. They were hoping that sharing their knowledge and experience of working in the community would allow them to make their field more accommodating for community organisations:

> '*we are constantly trying to make sure that the [NHS] priorities that are set right at the top reflect what is going on on the ground, so we are not trying to fit our priorities to something that in no way reflects reality*.' [Kate, Trustee]

Health Connections was therefore in a relatively strong position, together with other local third sector providers, to maintain some of its autonomy in public service delivery and shape its field.

Healthy Millborough was relatively well connected with other third sector organisations locally, amongst their trustees is the director of the local CVS and several others had roles in local charities. Rashid, the organisation's manager, was a member of the Local Strategic Partnership which brought together public sector, business and third sector leaders. Healthy Millborough was also part of a regional healthy living network set up to jointly bid for lottery money:

> '*so when the lottery announced another programme to replace healthy living centres it was a regional programme, so you had to have a regional spread so that's when all the projects formed a network (…). And then we were awarded £7 million over 5 years. (…) But if we didn't get that money the network would have just fizzled away because there is nothing in it otherwise.*' [Rashid, Chief officer]

There was however a strong orientation towards financial benefits and less appreciation of the potential strategic benefits of being involved in a network of similar organisations, as Rashid commented – '*but as most things, if there is no money in it, there is no point in putting time in it.*' Considering the gathered evidence, it is difficult to conclude whether the organisation was not taking advantage of the opportunities their relationships provided or whether the local institutional environment was particularly hostile for community organisations – both explanations seem plausible. The third sector in the town was on one hand closely connected by a network of personal relationships, on the other, there was an atmosphere of fierce

competition for resources and no collaboration had been established which could influence local decision making and shape the field. This "lone player" situation could have been undermining their autonomy as on their own there was little they could do to change their positioning in the field or local "rules of the game".

Overton Wellbeing Group members, particularly their chair Jill, collaborated with various groups and committees working in the neighbourhood anticipating that this way they could safeguard their organisations' interests. They also participated in training days and workshops organised by their local CVS which allowed them to stay up to date with current policy changes. Nevertheless the organisation's small capacity restricted its reach and influence in the field so their external relationships resulted in very small-scale benefits to the organisation. The role of its organisational environment was, however, equally significant. I found in the course of fieldwork that the voluntary sector had a relatively low profile in this locality and there was little support for third sector organisations. Neighbourhood initiatives, despite being set up by the local council as part of a government regeneration programme, received no further support from public bodies when the funding grant had come to an end. Emma, a city council manager who established the initial project and provided oversight while it received council money, expressed her deep frustration with the council's indifference to a well-established group of volunteers which had generated national interest and was commended for its innovative approach to community health improvement:

> '*Everyone else in the country wants me to go and talk about it [Overton Wellbeing Group], but here just don't mention it, because people don't really like it, it's not their pet project so they pretend it's not happening. (…) You can't win a lot of support from within this organisation [city council] or from within health. Nationally everyone is dead keen, it was ground-breaking, trailblazers they've called us.*' [Emma, Local authority VCS liaison officer]

Overton Wellbeing Group was a small, volunteer-run organisation and paradoxically, despite not being directly dependent on other organisations, its autonomy was compromised. It didn't have enough capacity to raise its profile locally and establish and maintain collaborative relationships with influential partners. This hindered the volunteers' ability to raise awareness of the social and health needs which remained unmet and provide the services they perceived would be beneficial to the local residents. The absence of institutional support therefore made having a recognised position in the health field unattainable and influencing it even more so.

I found that collaboration with other local organisations and having a collective "voice" can, as is demonstrated by Health Connections' case, facilitate a stronger position in the health field with new funding streams being made available and third sector organisations benefiting from a higher profile as service providers. Having some influence over local agendas potentially increased organisational autonomy as commissioners' expectations are tailored to third sector provision, therefore easing the restrictions placed on them in how they delivered projects. The three cases demonstrated that an existing hospitable environment and collaborative habitus fostered by public sector organisations facilitated community organisations to further improve their positioning. This leads me to conclude this chapter with a hypothesis of local "path dependency" which I suggest influences community organisation positioning in the field.

4.4 Local "path dependence": accounting for differences between local health fields.

Although the three studied organisations perceived their current environment as challenging and largely unfavourable, I found that a local institutional context that valued the particular strengths of community organisations and had a collaborative habitus could facilitate organisations to work according to their ethos and remain sustainable. It can be concluded that some locations provide more "room" for community organisations than others and having mentioned this observation to several of my respondents, a suggestion of "path dependence" has emerged.

Healthy Millborough and Overton Wellbeing Group have lost the autonomy to deliver the services that they believe meet the needs of their local communities through the breakdown in their relationship with their local council/NHS. In the case of Healthy Millborough, the local council declared support for community organisations, but from the accounts of respondents it can be concluded that their commissioning process disadvantaged them:

> '*And it is really just understanding what it* [the Compact[6]] *is, what it's meant to do, it's meant to support third sector in having a level playing field, for commissioning. (…) I don't think half of them know it exists. The directors do, the chief execs do, the director of public health does, but the commissioning managers who write service specs, they've never heard of it to be honest. And I would love to do a workshop with them to tell them what the Compact is. Because without that – they're killing us. Because we just can't compete'* [Rashid, Chief officer]

[6] The Compact is a document which sets out guidelines for effective collaboration between government bodies and third sector organisations.

Healthy Millborough also had no means of directly collaborating with the local NHS. Overton Wellbeing Group had experienced a complete withdrawal of council support for community organisations and community development:

> '*the council pulled the plug on a lot of things and left it to the community groups to take over*.' [Jill, Chair]

This was confirmed by Emma, who as an "insider" has failed to get community health initiatives on the council's agenda. With restricted funding and organisational capacity, these two groups were finding it hard to establish themselves as significant players in their fields, overwhelmed by the new "rules of the game" which included competition for funds and complying with present-day health agendas.

On the contrary, Health Connections' stakeholders agreed that their local area had relatively good relationships between public and voluntary sector organisations. It was speculated that this positive attitude towards community organisations and charitable work in the city dates back to Victorian times, a strong tradition of workers self-organising and industrial organisations looking after their workforce:

> '*It's always been poor, it's never been rich. Always had rickets and cholera, serious types of disasters. It always had the tradition of the rich coming in and doing nice, good things.*' [James, Commissioner]

There was noticeable pride in the local area about its social history as well as an acknowledgement by the local authority in recent decades that it needed the support of a strong voluntary sector to adapt to the town's rising social and ethnic diversity:

> '*I suppose also if [city] isn't a sort of settled community, it's always got new groups coming in, so no way can the statutory sector ever keep up with that.*' [James, Commissioner]

I was told by several people about the large range of small organisations working in particular neighbourhoods and how people naturally came together through common background or experiences:

> *'it seems to be a bit of a joke in the area, but in a good way, (…) literally there are support groups for everything.*' [Helen, Health Partnership manager]

It was acknowledged that the area has greatly benefitted from organised social action and there was a support network in place for those wanting to start new groups or activities:

> '*Because [city] has a robust voluntary sector, and has a lot of backing for that (…) We have voluntary outreach support officers in each area to help develop groups, people like myself in the council, who already have groups, but if new group came up I'd be able to say – oh, you should go here and you should go there.'* [Joanna, Commissioner]

This case demonstrates how the positioning of third sector organisations reproduces itself in a field; an existing strong voluntary sector allows new organisations to enter the field and gain support and recognition of their work. Health Connections had been able to take advantage of a local culture where third sector organisations are proactively supported by some statutory agencies and there are incentives for collaboration between organisations. These do not take away from the challenges related to limited resources and the escalating marketisation of the field, however the organisation had been able to draw on a broad support network and voice its ideas for a health system that is more receptive to community organisations whilst adapting to changes in its institutional environment.

Public sector institutions such as local authorities and NHS bodies could influence the likelihood of community organisations successfully reconciling autonomy and sustainability in public service delivery, although I have not found any existing research which would confirm this hypothesis. However there is some existing evidence about how local institutions shape the civic landscape and lead to significant differentiation in local relationships. Lowndes et al (2006) were studying the impact of local institutions on political engagement, but drew conclusions that support the observations made here about tangible and intangible differences in inter-organisational relationships within the studied localities. They found that the mobilisation of social capital is determined by the local institutional framework through 'citizen education and the provision of community facilities; capacity building and the support of voluntary associations; the design of public places; approaches to community cohesion and social inclusion; and, crucially, through the openness and responsiveness of their own decision-making machinery.' (Lowndes et al., 2006: 545). Contrasting two localities with similar socio-demographic characteristics but very different levels of participation they observed the impact of the way local government worked and engaged with communities on the organisation and coherence of the local voluntary sector; there were significant differences in the degree of co-ordination among civil society bodies as well as in their capacity to collaborate effectively with

local government decision makers. The politics of localism, advanced by the Coalition government from 2010 onwards, and the consequently emergent pluralism of local policies and ways of working are likely to further increase the differentiation of local government policy, provision and relationship building strategies across England (Rees & Rose, 2015). Deas et al demonstrate that the success of local partnerships and capacity building is heavily reliant on the pre-existing 'cohesion of actor networks' (2012: 733), particularly in circumstances of significant decreases in local budgets and a permissive approach to local variation. Their study applies to supporting structures for local economic growth, but I argue the same is also the case for support of third sector organisations and civic activities.

Diversity between local health fields is expected – there are undoubtedly multiple factors that shape them and the historical influences suggested above shouldn't be discounted. Nevertheless, the emerging differences between how well community organisations are supported in the local health field calls for further attention. Currently much consideration is given to internal organisational capabilities when discussing organisational success and failure (Milbourne, 2013), whereas in the course of my research it has become clear that it is the attitudes and ways of working of the "incumbents" in the local field which may have high significance. Therefore greater understanding is needed of how local authorities and NHS organisations, particularly those which work in areas of deprivation and poor health outcomes, can be encouraged to provide a supportive environment for small, local organisations, such as the community health promotion organisations which were the subject of this research.

4.5 Conclusion

This chapter has confirmed that relationships in the local health field are highly significant for organisational sustainability and autonomy. The community organisations' marginal positioning in the field, i.e. their relative powerlessness in relationship with other actors, meant that they had little influence over the changing "rules of the game". These were requiring them to take on characteristics of other sectors whilst they tried to remain committed to their mission and continue with preferred ways of working. Macmillan et al. found that 'securing or advancing 'room'' (2013: 19) in the field is a common concern in the third sector. This research shows that community health promotion organisations experience significant barriers, perceived to be associated with their small size and positioning on the periphery of the health field, when seeking funding and trying to build collaborative relationships. Community health promotion organisations are dependent on external funding from the local authorities or the NHS to deliver services (although as in Healthy Millborough's case, the Big Lottery fund was also a key contributor) therefore they need to participate in the

field of public service delivery. The challenge for them is adapting to the field to be able to enter it and improve their positioning to gain influence in it at the same time maintaining their distinct ways of working embedded in the forms of capital that they recognise as important (which may not match those which are highly valued in the field).

I identified three strategies employed by the two larger studied organisations to reconcile autonomy and sustainability in the health field. Firstly, organisations changed some of their practices to meet the requirements of the field and increase their chances of remaining sustainable – this leads to hybridisation (Billis, 2010c) which will be further discussed in the following chapter. I have found that this adjustment to the field did not happen "automatically" as suggested in the Bourdieusian theoretical framework (Bourdieu & Wacquant, 1992), but through a continuous reflexive process. Secondly, community health promotion organisations made every effort to preserve their "autonomy of purpose" (Independence Panel, 2011) as they strived to remain true to their community development ethos, a habitus that is often at odds with the habitus generated by the professionalised health field. Consequently they were positioned as "challengers" in the field, which may have made them uncomfortable partners for some "mainstream" health organisations. Thirdly, if they had sufficient pre-existing capital resources, the organisations tried to gain enough influence in the field (possibly with the collaboration of other organisations in a similar position) to "change the rules of the game". This process of making "room" would allow them to maintain more autonomy whilst remaining sustainable. These three approaches are not mutually exclusive and they were similar in requiring organisations to have the capacity and capital to successfully negotiate an advantageous positioning in the field. As demonstrated by Overton Wellbeing Group, this cannot be assumed.

I have concluded that community health promotion organisations are dependent on other, more powerful actors in their field to value the forms of capital they have and make "room" for them to improve their autonomy and sustainability. Nationally, government policies and austerity measures have created an unfavourable environment for small organisations that deliver community-centred health promotion. I have demonstrated that organisations which work in a local institutional setting which is favourable to community organisations and where they can collaborate successfully, have the footing to gain some influence in the field. It is therefore necessary to carefully consider the qualities of organisations' institutional environment when examining organisational resilience strategies in circumstances of austerity and marketization.

Chapter 5

Organisational habitus: the tensions of hybridisation

This chapter focuses on the culture of community health promotion organisations which I will be discussing through the theoretical lens of "habitus" – the open system of organisational predispositions which, although firmly rooted in the organisations' social origins, is inherently adaptable and responds to stimuli from the field (Bourdieu & Wacquant, 1992). Habitus is reflected in organisational values and beliefs and defines how individuals and the organisations as a whole will behave in particular circumstances. Organisational habitus therefore shapes preferences about "ways of working" which may not be explicitly defined within an organisation, but are enacted in everyday practices and interactions. Examining organisational culture is an important aspect of this research because it contributes insight into the organisational "lifeworld", including key third sector drivers such as values, mission and ethos which contextualise behaviours, strategies and relationships.

In this chapter I argue that the organisations' habitus, and consequently their ways of working, are increasingly influenced by the expectations of their institutional environments. Firstly I present the characteristics which lie at the core of their organisational culture and identity: remaining uncompromised in their mission, community development ethos and enabling approach to health improvement. These keep them rooted in the third sector and are fundamental to the organisations' autonomy. Then I discuss the pressures on organisations to adapt to the field to remaining sustainable in a target-driven, marketised environment. They were choosing or being required to take on ways of working characteristic of the public or private sector to meet the expectations of funding bodies and to be a viable player in the market, developing new sets of practices. I describe how consequently their cultures started to "hybridise" to accommodate these changes, taking on some elements of a "heirarchist" and "individualist" way of working (Hood, 1998). In the final part of the chapter I discuss the challenges organisations face in trying to adopt a "hybrid habitus".

5.1 Community development ethos

Billis suggests that "commitment about distinctive mission" (2010c: 55) is the operational priority of third sector organisations. Although health improvement is a policy objective that drives many public sector bodies, and equally there are numerous private sector organisations offering customers health and wellbeing services, community organisations are often set up to respond to unmet needs which are specific to particular locations or population groups.

Currently such organisations are working in a challenging institutional environment are at risk of "mission drift" when seeking the funding and support needed to remain financially sustainable. My research confirms that this risk can be mitigated when particular values and beliefs are firmly embedded in the organisational culture. This section demonstrates that the success of community health promotion organisations in engaging disadvantaged groups in health improvement activities is a result of the organisations cultivating a particular approach to health promotion and style of work rooted in the habitus of the people working in the organisations.

The three studied organisations delivered different kinds of services, however they had a common approach to health promotion, focused predominantly on the psycho-social aspects of health and aiming to achieve intangible, long-term outcomes for their service users. A community development ethos prevailed in the practices of the organisations' leaders and community workers. This can be certainly considered a fundamental part of the organisations' habitus, consciously and subconsciously enacted in their daily work:

> '*the community development sort of approach is what they understand I think, not the theory of it, but they're doing it, they understand the application of it, the whole idea of working with people from where they are at, it's a style of working, they would be working in that way without realising a lot of the time.'* [Emma, Local authority VCS liaison officer]

Empowerment was a key focus in the activities I observed and one of the key categories used by my interviewees to explain their work. It was most commonly associated with increasing the sense of control over people's lives through providing them with the appropriate resources and a supportive social environment. Empowerment is a contested notion, but here will is understood as:

- applying to individuals and collectives,
- dealing with issues of power and control over resources and individual lives,
- focusing on capacity and confidence building and
- involving active participation (Rifkin, 2003: 170).

This organisational habitus which enables this approach to health promotion has two foundations: the values and beliefs about the nature of health and the aims of health promotion and the predispositions which allow community health workers to successfully engage with members of socially excluded groups. In my interviews it was very clear that

individuals were driven in their work by personal values and beliefs, which are part of a habitus that was often shaped by significant previous life experiences. It also struck me how comfortable the community workers were with community members and how they made them feel at ease, something that can also be credited to their personal predispositions and "way of being" with others. These two aspects of organisational habitus, as personified by the individuals involved in the work of all three organisations, are further discussed below.

5.1.1 Values and beliefs

The organisations base their work on the positive model of health, and although it is unlikely that they have ever heard of Antonovsky's salutogenic model (Antonovsky, 1996), they essentially apply this approach, building up service users' positive resources that support health and wellbeing. Nicky, who is a senior community worker at Health Connections, described her work aims in the following way:

> '*my little boy who is 3 asks me – mummy, what do you do for a job? (…) But when I say I make people feel better he says – but mummy, you're not a doctor. So then I make people feel happy. And we do, we just make them feel better, about themselves, about their health, (…) because if you feel confident, then you feel better about yourself, (…) We just make people feel better, but in a very huge way*.' [Nicky, Community health worker]

They deliberately reach out to people that are less likely to access or respond to mainstream health services, providing opportunities for them to get engaged in social activities, assisting the formation of social support networks and sharing of knowledge. The organisations fundamentally aim to bring about broader social change through empowering people to take responsibility for their health and that of other. They believe that people and communities can, to some extent, help themselves live healthier lives if given the opportunity and some facilitation, as expressed by Joan, a longstanding Health Connections trustee:

> *'I think any change, whether you are going to change your lifestyle or if you are going to come to terms with changes that are forced upon you by long-term health conditions, you need a lot of support to do that, (…) if you have no one working in your family, you live in poverty, again these are all things that sap you energy and your confidence, (...) I would hope that also while we are running a group about exercise, they're building relationships with us and with each other, we're building confidence, we're giving them information, we're encouraging them to be more confident people, because in fact, I think your health relates, probably more than*

anything else to your self-confidence and your belief that you can change things, if you don't feel that you have any power to control anything, then that's probably going to impact in all sorts of ways on your health, negatively.' [Joan, Trustee]

They held the belief that feeling good about oneself and feeling able to cope with life improves wellbeing as well as allowing people to take steps towards making appropriate lifestyle changes. The organisations recognised the significance of the social determinants of health (Whitehead & Dahlgren, 1991) and acknowledged that poor health is often related to multiple other challenges that individuals experience in an adverse social and physical environment. Kate, a trustee and former employee at Health Connections, explained how their experience of working in the community supports this as an effective approach to health promotion:

'If I eat badly, it's not always about not knowing what to cook, it's about the other factors in my life and that's where I think the holistic approach matters, I think, what we found with Health Connections is that we very much ended up cross-referring, someone comes with obesity and it turns out that they're actually quite isolated (…). And that's all really important, is seeing people in a whole and relating to them in that way, without that, it's not going to be effective.' [Kate, Trustee]

She further pointed out that '*they're not issues – they're people'* suggesting that other agencies may treat unhealthy lifestyle choices as "issues" that need resolving, not as people that need help, disregarding the often complex interplay of personal circumstances they are entangled in. The organisations' primary focus was therefore on meeting a broad spectrum of social and psychological needs, not solely particular 'conditions' or lifestyle choices. One of Overton Wellbeing Group's stakeholders explained how this approach makes it possible for the organisation to fulfil a distinct role in the health system:

'a holistic approach really, so that you involve people, you work with them from where they're at but always trying to move in a positive, it's a positive step towards health and wellbeing, they're not forcing an agenda so there is no failing going on, so people don't fail to achieve. I think that's really important, they work with who they've got rather than trying to fit people through a system which happens a lot with big public organisations like the NHS, you have to fit in with them.' [Emma, Local authority VCS liaison officer]

Mental wellbeing was an important aim for the organisations' work. Every contact with service users was seen as an opportunity to develop personal confidence, relationships and a sense of agency – a route to empowerment. Kirsty, Healthy Millborough's community dietician, ran a weight management programme which was accessed predominantly by South Asian women – a social group that is known to have significant health risks and with which public services have difficulty engaging with. Her aim was to improve the physical health of participants through dietary changes and increased physical exercise, but asserted the psychological benefits may be as important to achieve:

> *'even if they don't lose any weight, but they're like, I actually do more exercise and I feel so much better, I <u>feel</u> better rather than I've lost weight, then I'm happy with that as well.'* [Kirsty, Community Dietician]

Improved social relationships were the second significant objective, particularly working with people who are isolated, vulnerable and experiencing social exclusion. Health Connections had a project dedicated to working with asylum seekers which aimed to improve their mental health through facilitating their integration into the local community. One of the ways they did this was by supporting them in joining social groups and activities that were meaningful for particular individuals, where they could benefit from recognition and a sense of belonging:

> *'It's practical things, it's about taking an asylum seeker to a rowing club, because he is a rowing champion in his country of origin, (…) and he's now engaged, and it's something so simple. It's very simple. But his mental health, his contribution to society, up a hundred times.'* [Patricia, Manager]

This was a service that the organisation was extremely proud of, and even people who were not directly involved in delivering it, eagerly spoke about how vividly it represents the organisation's values:

> *'the thing I'm proudest of is the refugee and asylum seeker programme. Because (…) we saw a need, and it wasn't a sexy need (…), but we went in there, and we did it, and we did it right. We are saving lives through that programme, (…) people who come to this country, who have nothing, who are severely traumatised, ostracised by society, they have nothing materially, they are physically and mentally often in very bad shape, and we work with those people intensively, for however long it takes, to get them back on their feet and for them to have a life*

again. For me, the fact that we developed that programme and it's so successful is such an achievement, (…) and it also epitomizes who we are' [Kate, Trustee]

The organisations recognised that social exclusion and isolation, which can result from a range of circumstances such as lack of financial resources, mental health problems, poor physical health or bereavement, can have a devastating effect on people and impact all aspects of their life and health. Through their experiences they were very aware of what research has shown – that social capital is 'a mediating link between socio-economic inequality and health' (Swann & Morgan, 2002: 3). Therefore they made a particular effort to facilitate social interaction and participation and establish self-supporting community networks which people could draw on.

The importance of talking (and cooking)

I participated in a "Cook and Eat" session facilitated by Healthy Millborough's community dietician Kirsty as part of a NHS funded substance misuse rehabilitation programme. It was the last of a six session course and the 3 participants (3 others were unable to attend due to unforeseen circumstances) were eagerly sharing their knowledge and skills with each other (and myself – I learned a trick or two about making pastry). During the meal they were giving feedback about the course to Kirsty, which then turned into a conversation about family life and cooking with kids. Although they all acknowledged that the course has encouraged them to cook more for themselves and their families, they also said that more importantly they learned to share, communicate and have "normal conversations" and particularly appreciated the good atmosphere in the group, feeling welcomed and encouraged to get involved.

I also participated in a Cook and Eat group with men suffering with mild mental health problems and isolation at Health Connections. One of the participants, Henry, was a charming, 80-year old, widowed gentleman. Clare, who ran the group, told me that when he started attending several years previously *'he could barely boil an egg'*, but recently had proudly baked a cake for a party at Health Connections. Clare however commented that despite some healthy eating messages and skills being passed on, essentially '*it's more about the talking than about the cooking'*. Both community workers running Cook and Eat sessions saw the value of having an opportunity to talk and just enjoy food with other people, with the process being more important than immediate outcomes:

'it's like the actual interaction with the group, particularly with the group that we've just seen, (…) they thought - I don't think I can do that but I'll give it a go, and then they thought – I can do that actually, check me out! And they're much more likely to try something else and take responsibility for other parts and it all kind of links together and builds up.' [Kirsty, Community Dietician]

I certainly enjoyed the food and the company on both occasions.

All three of the studied organisations had a clear sense of mission and it was noticeable that the "feel good" aims commonly took priority over the more tangible outcomes and targets that were assigned to them by their commissioners. This is the specific niche that the organisations believed they are able to fill in the local delivery of services, as public sector organisations were primarily focused on meeting basic welfare needs and achieving more

tangible, measurable outcomes in terms of prevention and health improvement. Similarly to the doctors who set up the Pioneer Health Centre in Peckham (Scott-Samuel, 1990), they believed better health can be enabled through developing their service users' personal and social resources. 'Self-realisation comes through the nature of our social relationships, civic duties and creative activities' (Dean, 2010: 101); the community organisations therefore provided valuable opportunities for involvement, personal development and fostering social relations in the neighbourhoods they served.

5.1.2 Personal predispositions

Successful community engagement requires not only knowledge and experience, but also the ability to gain trust and acceptance in communities, sometimes ones where the health workers don't naturally "fit in". This was facilitated by the habitus of community workers: personal predispositions gained primarily in the process of socialisation in people's families and social groups. Individuals brought these predispositions with them into their work and they constituted an important aspect of the organisations' cultural capital. Such predispositions were referred to when I asked managers about recruiting employees who would "fit" the organisation and be well suited to community-centred work. Rashid told me that he took a "tick box" approach to the first round of recruitment he carried out for Healthy Millborugh, but for further recruitment took advice from the chair of trustees, an experienced third sector manager, to go more with "gut feeling" and that is how he got his best, most dedicated staff. Pete, the finance manager at Health Connections who often sat on interview panels described that they were looking for someone who would match the organisations' habitus, doing things the "Health Connections way":

> '*there is always an element of, they might be very, very good at what they do, but do they do it the "Health Connections way"? (…) A different organisation may want someone to come in and be* [pause] *soldier-ish about something. "Right – this is what we do, this is how we do it. Right we need to do this." And forceful and very pushy, bossy. Whereas maybe we do something a little bit different (…) I say it's the "Health Connections way", but maybe we've seen a different approach works best for some of our groups*.' [Pete, Finance manager]

They aimed to employ people who would holistically approach each service user, look beyond first impressions and be non-judgemental in dealing with individuals who are struggling to cope with a variety of life circumstances. Patricia emphasized that she wanted her team at Health Connections to be able to see the wider picture, understand how social circumstances

influence wellbeing and be prepared to reach out with empathy to those who need support, particularly in situations when blaming, stereotype-based judgments are easy to make:

> *'I want a team that knows what it's doing and is passionate about making a difference to addressing injustice and inequality – they're the key. How, when we see a young mum struggling in ASDA and you can tell she's over laden, she's got a load of shitty food in her basket (…) and the baby is crying, and snotty, how can I help that woman <u>really address</u> what is going on and help her feel better for herself?'* [Patricia, Manager]

The organisations also championed an egalitarian relationship between the health workers and service-users, following the view that empowerment in health promotion is 'a democratic concept looking at the structure of power and a process of professional activity and a relinquishment of the professionals' power' (Lindström & Eriksson, 2006: 243). Consequently, they aimed to establish relationships which are qualitatively different to ones typical of the healthcare environment:

> *'it's about engaging that person, valuing them for who they are and not telling them what to do, but enabling them to take control of their health and their life. So it's really empowering value, and you will find that in all the people you engage with at Health Connections there is never an approach of "I'm going to tell you what to do" or "I'm going to tell you anything" actually. It's about I'm going to listen to you and then, if I've got information that's useful to you, I'll give it.'* [Kate, Trustee]

There was a strong belief in the value of personal autonomy: working with each person on their own terms, even if that meant that only small changes were achieved. Prior to working in Healthy Millborough, Kirsty was a dietician in a hospital clinic where patients would come to her for a set plan for achieving weight loss, something that she found very frustrating and ineffective:

> *'It doesn't quite work like that. I mean, I can, but if it doesn't work for you, it's your body and your choices. (…) and at the end of the day it's about choice, it's their choice if they choose to do the healthiest version or something varying in between or stick with what they like.'* [Kirsty, Community Dietician]

In her current work she focused on giving information, teaching skills and providing encouragement, allowing people to make lifestyle changes that suit their circumstances and

cultural practices. She told me – *'I'm not an expert on their life'* so sees herself as their partner, not someone in a position of authority. Being rooted in the community was found to "de-professionalise" community workers and volunteers in the eyes of service users so they are not seen as people in positions of authority. They often were people who the service users could identify with and feel that their circumstances are empathised with:

> *'Now people feel more confident coming to talk to us than going to someone in authority, we're residents, we live in the same area, we know all the problems in Overton, people trust us as well, there is a great amount of trust built up between us, I think it works, rather than having somebody come in from outside, from a department in the council, a faceless person. People won't open up, but they'll open up to us.'* [Jill, Chair]

This is what my respondents believed allowed the community workers to be accepted by and engage with "hard to reach" groups in their projects.

Several respondents pointed out that professional boundaries and organisational ways of working often restrict health professionals in their engagement with individuals and communities, as explained by Omar, a community worker at Healthy Millborough:

> *'And if you're looking from a health perspective, if you ask the majority of health professionals they cannot, or do not have the necessary skills to engage with communities really at the ground level (...) So we have those arms, we have that experience and we use them.'* [Omar, Community health worker]

Having this kind of relationship requires the community workers to have certain personal predispositions, a way of being and presenting themselves that would allow community members to see them as approachable and trustworthy:

> '*the people we employ to engage with the community they don't come with 800 degrees, although they are very well qualified, they are from and out of the community, they are down to earth, they talk to you on a level, they can come out with all sorts, they're just normal ordinary people, they don't come in wearing white coats, (...) So you know, Nicky, she's a thirty-something mother of two and yet she is hanging out on a bus on Friday night with fourteen year-old lads. And she can only do that because she has really strong skills there, at a level with them. And yes she shows her authority when she needs to, she has to keep control, but*

she's not come there with any attitude at all and that's absolutely vital.' [Kate, Trustee]

The comment about not wearing a "white coat" was meant to be metaphorical, but could also be taken quite literally. I noticed that community workers were very casual in their style of dress and, as one respondent said (who asked not to be quoted on this), they were '*sometimes even a bit scruffy*'. The community workers were able to be very genuine in the image of themselves that they presented to service users and that gave them significant credibility:

'being able to not be uptight and this – I work for an organisation you're a community member, being able to go to that level and for them to feel – oh, they're humans, we're all the same at the end of the day, and being able, it's that rapport that you need to build with the community and that's key.' [Chandra, Community health worker]

As I observed their work, they were very confident but unpretentious and cheerfully accepted friendly teasing:

'And I'm not afraid of taking the Michael out of myself, as you know, so people know I don't take myself so seriously' [Omar, Community health worker]

This allowed them to form relationships with service users that were perceived to be supportive and not imposing:

'*we started to understand what you can say to who and not offend them and what the banter was and why they were saying it to us. And we developed that relationship*' [Chandra, Community health worker]

I observed them carefully in their work with particular attention to the nature of their relationships with service users. I found that these were typically very friendly and personal, and often were maintained beyond the actual project work. It was obvious to me that their habitus reflected their modest social background or previous formative encounters with socially disadvantaged groups, which is what made them the "right" people for the job.

'Part of the community'

To interview Pauline, a retired pub landlady, local church warden and "community organiser", I took a bus from Millborough's town centre to the boundary of one of its poorest, and most notorious white-working class estates and after a 7-minute walk reached the local church hall. I arrived towards the end of a meeting regarding a new Big Lottery-funded community project which had a significant budget, but was conditional on community members getting engaged in its planning and implementation. This meeting was chaired by a woman from a consultancy company which was assigned to manage the project. Despite her best efforts, only three local residents turned up to the meeting and they were not showing any engagement with the project. Pauline later commented: 'She won't ever fit in here'. I had to agree: she was wearing a pinstripe suit and high heels, carried a briefcase and then drove away in her shiny new sports car which had been parked, rather inconsiderately, right in front of the hall steps. In contrast, Pauline considered the community workers from Healthy Millborough to look and behave *'like normal people'* and to be *'part of this community'* despite all of them being "outsiders":

'*And Omar and Rashid and Alice* [community development manager] *and everything they just fit in, they're part of it* [the local community]. *I don't know how they feel about it, I don't know whether they'd say that they felt like they were part of it, but I certainly feel that they're part of it. (…) And I think they are accepted in the community. And they've done that in quite a short time as well, to be fair, but I think they know most of the movers and shakers in the area*.' [Pauline, Community leader]

It was 6pm when I finished the interview and it was already dark outside. Pauline asked where I was going and how I intended to get there. I confidently replied that I was taking the bus back to the town centre. 'Oh no, don't risk walking through the estate on your own, I insist that you get a lift back'. My protests were dismissed so I accepted the offer and spent the rest of the evening thinking about the several pieces of evidence I now had (also from other interviews) about how strongly this community felt about the presence of "outsiders". Other studies found similar attitudes of mistrust on deprived estates in other parts of the UK (Knight 1993 in: Lindsey, 2013; Pearce & Milne, 2010). This experience really emphasized that having a particular habitus, which allows community workers to gain the trust and approval of community members, constitutes a key element of their cultural capital. This gives them their unique positioning in the health system (South et al., 2011) and facilitates access to hard-to-reach groups.

I found that the three organisations' health promotion work was strongly rooted in a community development approach which requires an egalitarian "way of life" (Hood, 1998), with little "rules" about how they work but high importance of social cohesiveness, empowering people and being inclusive in decision-making processes. Maintaining aims and ways of working which are congruent with the habitus of the people involved in the organisation was fundamental to the studied organisations' autonomy. I am convinced that these deep-seated beliefs and predispositions were the most effective safeguard the organisations' "independence of purpose" (Independence Panel, 2011), as approaching health promotion in any other way would seem entirely alien to people working there. Nevertheless their organisational habitus became problematic when confronted with the expectations of some external stakeholders and potential funders, who the organisations are largely dependent on to deliver their services. These conflicting requirements of the field will be explored in further sections of the chapter.

5.2 "Professional" image

The influence of public sector commissioning organisations, which are predominantly NHS bodies or local authorities, is of particular interest when examining the ways of working of community health promotion organisations. As discussed previously, community organisations were inevitability interdependent with other organisations in their field. Particularly the endorsement of statutory agencies was crucial for them to remain sustainable, both in terms of accessing financial resources and being able to form mutually supportive working partnerships with core public sector services. Having to seriously consider the expectations of other actors in the field was relatively new for the organisations – they were initially funded through grants and given considerable freedom in establishing their desired outcomes and methods of work. Nevertheless changes to funding arrangements were brought about by firstly, the organisations gaining independence from their "parent" statutory bodies and secondly by public policy changes and financial austerity.

Managing the requirements of the commissioning process such as delivering measurable outcomes, meeting targets and delivering "value for money" is part of the expectation that community organisations will behave as "professional agencies". The commissioning "rules of the game" were at best bureaucratic, i.e. aligned with a hierarchical "way of life" (Hood, 1998), and at worst 'determined by the prevailing ethos of financial managerialism, which claimed normative judgements on what represents value for money and efficiency and effectiveness as technical assessments' (Kelly, 2007: 1013). The inclination of statutory organisations towards more "traditional" providers was repeatedly highlighted as a critical barrier to the

organisations' sustainability, even by external stakeholders like Janet, a community projects manager in a Millborough housing association:

> *'for small business, social enterprises, charities, sometimes actually getting the buy-in from larger organisations is quite difficult, because a number of larger organisations and commissioning bodies have that bureaucracy and you know, people have to be able to jump through hoops, to meet all the criteria, it is quite difficult for charities and smaller organisations to be able to jump through those hoops because they are not set up and they are not structured in the same way.*'
> [Janet, Housing association community projects manager]

The managerialism agenda had been carried over into the third sector in the process of "adapting" it to public service delivery (Harris, 2010) through incorporating rational planning and managerial judgements into their working culture. It is a technocratic ideology focused on achieving policy objectives, and therefore 'decisions are made not based on professional expertise, and certainly not based on the views of communities served, but based on managerial prerogatives.' (South et al., 2013: 155).

However the organisations' external stakeholders also incorporated another set of ideas into the term of "professionalism": the range of knowledge and skills gained through education and socialisation into working practice which lead to acquiring a "professional habitus" – the embodiment of dispositions that define ways of perceiving, thinking and acting (Schinkel & Noordegraaf, 2011a). Health "professionals" have certain standards that they are expected to adhere to, for example working in the best interest of service users, acting within their scope of competence, maintaining confidentiality and upholding public confidence (Health & Care Professions Council, 2012; Nursing & Midwifery Council, 2015). Schinkel and Noordegraff theorise "professionalism" as a form of symbolic capital: cultural capital (such as particular forms of knowledge) that is transformed into symbolic capital when its 'corresponding embodied dispositions', i.e. a professional habitus, generates practices that 'bear the mark of "professionalism"' (Schinkel & Noordegraaf, 2011b: 88). However defining what in a particular field is considered as acting in a "professional way" is a stake that is competed for and gives considerable power:

> 'professions are then networks of positions that successfully claim professional capital and that, in doing so, are able to dominate over occupations unsuccessful in doing so' (Schinkel & Noordegraaf, 2011b: 87-88)

This has further implications for community organisations' symbolic capital and will be discussed in the next chapter.

Nevertheless "managerialsim" and "professionalism" designate two, to some degree, opposing sets of values and ways of working in the health field with health professionals and managers often seen to have competing interests (Schinkel & Noordegraaf, 2011a). Furthermore, both are different to the lay model of community work which prioritises 'community participation and ownership' and taking action on 'community not professional priorities' (South et al., 2013: 44). South et al. (2013) question the legitimacy of the expectation that the clinical expertise of medical professionals is necessary when supporting people in lifestyle change. Instead they argue that:

> 'Moving away from professional monopoly in public health inevitably entails greater acceptance of the lay contribution. (…) successful programmes draw on the strength of both.' (South et al., 2013: 156)

The studied organisations were predominantly addressing the *social* determinants of health and running community activities, therefore I found myself questioning whether they need to be "professionals" or just adequately trained individuals with the right personal dispositions? I saw how this conflict of expectations played out for community health workers: on one hand they wanted to be recognised by health professionals as peers who are competent in their field of work, on the other, as presented above, they deliberately distanced themselves from the "professional" approach and way of working in their daily practices in the community.

In addition to being able to meet formal criteria, all three organisations perceived that they had to employ "identity management" – presenting themselves as "professionals" with the right attitudes and predispositions to gain recognition as competent partners and some influence in the field. The two larger community organisations in my study, Health Connections and Healthy Millborough have therefore been attempting to *'just jump through the bloody hoops they keep putting up'* [Rashid, Chief officer], whereas Overton Wellbeing Group did not participate in commissioning. The value of this "symbolic capital" will be discussed in the next chapter, here I will present the organisations' efforts to shape a "professional" habitus.

"Amateurism" is a common criticism of third sector organisations which has long been acknowledged in academic literature (Salamon, 1987). My research demonstrated that community organisations see this as a threat to their public image that they must contest:

'*people think of charities as little corner shops that just take money and sell second-hand things. Whereas this is a professional organisation of professional people and some of the work is certainly on the par with what you would get in the private, commercial sector*.' [Pete, Finance manager]

My respondents from Health Connections and Healthy Millborough, despite their third sector roots and community values, were attempting to dissociate themselves from the "voluntary" sector image, acknowledging that their ways of working differ from those organisations which are dependent primarily on volunteers:

'*that is why I don't use the word "voluntary" sector, I use "third" sector because we are not voluntary, we are proper organisations which are delivering excellent services which are not-for-profit*' [Patricia, Manager]

Joanna, Health Connections' Social Care commissioner, praised their "professional" way of working:

'*So most definitely, I think they are quite professional in their, not only in their approach, but in the aims they wish to achieve and how they go about them (…). They're very good at paperwork returns and stuff like that, (…) I think they set out to achieve things in a very organised and quite a professional way.'* [Joanna, Commissioner]

I found that the organisations' "professional" image is closely correlated with that of their managers. Studies of third sector leadership found the 'communicative 'ambassadorial' dimension in leadership' (Macmillan & McLaren, 2012: 6) to be highly significant. It is this "ambassadorial" role in which the managers from this research were most heavily scrutinised as they personified their organisation's habitus in the eyes of external stakeholders. It was expected that they presented their managerial credentials as well as the ability to articulate their organisation's purpose in a way that is meaningful to health professionals. Each organisational leader in the three organisations works in a different set of circumstances and therefore the demands placed on them were varied. However undoubtedly it was the diversity of personal, formative experiences and their resultant habitus which had the greatest influence on how each of them had constructed their role and was perceived by others in the health field.

Health Connections' professionalism was commented on by many of their external stakeholders who indicated that this made the organisation an attractive partner for

collaboration. Steve, a trustee, was one of those who associated this directly with the quality of Patricia's leadership:

> '*She's* [Patricia] *pretty good at some of the things that I've described* [NHS commissioning changes and responding to the market] *as dealing with them, anticipating them. So I think the figurehead manager (…) is a pretty important key player really, because those external relationships I talked about are predominantly down to her in the commissioning area'* [Steve, Trustee]

Patricia had a degree in humanities and had worked in community roles since she was a student, first as a volunteer, then as community worker:

> '*At university I set up the student Community Action Group and looked very much into how can students get involved in volunteering, I was very passionate about volunteering (...) and did a lot of work with Age Concern which had a really good befriending scheme set up. And then when I finished my degree there was a bit of money left and they asked me to do this [be intergenerational worker at Age Concern]*' [Patricia, Manager]

She had brought broad experience and a high level of self-confidence to her role as manager at Health Connections. Patricia was a strong-minded leader who came across as very articulate and persuasive. Her collaborators held her in great esteem and commented on her ability to lead the organisation in a challenging environment, as described by one of Health Connections' trustees:

> '*I think she's [Patricia] great at her job actually; I like what I call her entrepreneurial spirit and her confidence in taking risks. If she was what I call "old world voluntary sector" I don't think I'd be sitting here. She's what I call "new world" in voluntary not-for-profit sector.'* [Steve, Trustee]

It was clear that Patricia's personal habitus facilitates building the organisations' strategic relationships.

Healthy Millborough also aspired to be perceived as a professional organisation and I would argue that from a formal point of view they certainly were. However only one of my respondents, a trustee who was also the chief executive of the Millborough CVS, referred to this as an organisational strength:

'so just how the papers are presented, the reports, what they are reporting on, so yeah, for my perspective it comes across as a well run charity, by a lot of committed professionals' [Gerald, Trustee]

My observation was that they were not as proficient as Health Connections in promoting a professional image of themselves; this may have been partially caused by insufficient organisational capacity in terms of staff time (which is discussed in the following chapter), however I would also argue that this is not part of their habitus. Rashid, the chief officer at Healthy Millborough, became the organisation's manager after many years of working as a council community development officer. He was very driven and very involved in front-line work and acknowledged that the strategic, business side of managing a small organisation which required dealing with documentation and finalising projects with evaluation is not an aspect of his role which he is keen to spend time on:

'*Things that really turn me off are doing reports, doing plans, doing strategic plans, doing action plans – that's part of my job now, but it's not something I would rush, I would run to do (…) I'm very good at starting new ideas, getting them going, I'm not very good at finishing them off – that's going to somebody else, because that's not as exciting [laugh]*' [Rashid, Chief officer]

He was well supported by a community development manager and a finance and administration manager, however it was clear that the organisation's strengths lie in generating innovative projects and building relationships within the communities they work with, not in particular consideration of their relationships with external agencies.

Rashid's story

Rashid was born in a Pakistani family in Millborough sometime around 1970, and had since distanced himself from his cultural origins. His story of progression from volunteering and political activism to a leadership role is not uncommon in the third sector; what may be slightly more unusual is reaching this status as someone whose working class and minority ethnic background have markedly shaped his habitus. I clearly saw how, on one hand, this is a great advantage in his relationships with community members and his staff, many of whom are from a similar background. On the other, it constitutes an impediment to his professional relationships. Here is how he tells his story.

'*I was 17 years old and at the time I used to work in a high street store, I was stacking*

shelves in the shop, I was working in a warehouse in Boots, so I was in a dead-end job, I wasn't going anywhere, I was happy because I was earning money, I wasn't unemployed. I used to attend our local youth club, which I'd been there since 15, 16, and one summer we did an art project, and this building, like an old church-type school, and it had a very big wall in the middle and it was about 30 foot high, (…) so we did a mural, about 10 young people, all young men and the youth workers, and we did a very political mural. About lots of political statements about racism, about pollution, about kind of apartheid, because this was the mid 80's, and all these issues on this big wall, (…). And so the council panicked, because it was just before the local elections and we had Maggie Thatcher up on the wall, Northern Ireland on there, we had everything on there. So they kind of covered it up and then to cut a long story short they painted over it, painted over 6 months of work. (…) We got a very early lesson in politics and how politicians don't always stick to their promises and how they lie to you. A politician came to our youth centre and said "no, I think that's fine, I'm happy with it" and the next day he asked for it to be painted over.'

'*I mean I, even though I manage a health charity, I am not a health professional, I have no health training,* [whisper: *I have no training at all but that is another matter*] *(…). So my progression has been over the last 22 years from a volunteer, to where I am now I suppose. And quite, I don't quite know how I got here, and um, I'm still thinking I might be found out soon and you know…*'

Rashid openly admitted to discomfort in the company of people he perceives as influential and seemed acutely aware that he needed to work hard to look like he fit his role:

'*no matter how many meetings I got to, I don't always feel comfortable in those meetings because I don't obviously want to make a fool of myself, but always end up um [pause] saying something, as I just want to be seen, to be heard at the meeting (…). So I want to be known, so I always kind of suit up for them'* [usually comes to work in jeans and t-shirt]

'*it's something that doesn't come easy to me that networking, I can network and I can work with people, but kind of, some people do it easier than others, (...) and I'm getting better at that, I have to if I want to survive, so that's kind of my mission at the moment, to kind of build up those networks*.'

He was relaxed in my company, but suddenly became quite self-conscious when I switched on my Dictaphone, saying half-jokingly: *'I'll have to watch my p's and q's now!'*

In terms of "professionalism" Overton Wellbeing Group differed considerably from the other two organisations; it was entirely volunteer-run and funded from a small community grant. The volunteers were enthusiastic about working with local people and, despite having completed appropriate training, wanted to be recognised in their roles as lay workers, not as "professionals". Here is how Sharon, an Overton Wellbeing Group committee member explained this:

> '*We can't give them the answers, we can only advise them on what we know, because we're not authorities, you can't pretend to be something you're not, you're just a volunteer*.' [Sharon, Tai-Chi coordinator]

The organisation had therefore retained a "non-professional" organisational image. Overton Wellbeing Group had consciously chosen to only fulfil the minimum formal requirements for running their services, although Jill, the Committee's chair, was keen to emphasize that they had to have formally run accounts, document risk assessments and complete recognised training courses to run their activities. They had no system for monitoring and evaluating their work which was likely to significantly decrease their chances of obtaining further public funding. However there was little regret and plenty of pride amongst the volunteers about managing the organisation on their own, without their previous local authority support. Several of my respondents had emphasized that this had given the committee considerable sovereignty and as far as possible, allowed its members to remain unbound by external requirements and hierarchical relationships:

> '*some of that* [support from council workers] *was more of a hindrance than a help. (…) I mean since Jill has become chair, it is so much lighter, the volunteers are happier, (…) they do it the way they want to do it, not the way they're told to do it, they've taken on their own identity, and it's like blossomed.* [Stacey, Health trainer]

Jill who was chair of the committee running Overton Wellbeing Group was a retired nurse who had to fight for her right to join the profession after childhood polio, and a passionate community organiser. She was resolute, but not naturally self-confident, although she acknowledged that this had changed since becoming the chair of Overton Wellbeing Group:

> '*I didn't have a vice-chair and I had to do everything, and I was on my own, and I had a lot of work to get through. But I found that by doing that, cause I had to do it, I've grown in confidence, it's really made my confidence. I've got to that now*

that I will sell Overton Wellbeing Group, I know what I'm talking about, and I will go out and I will sell it.' [Jill, Chair]

I found Jill to be very even-tempered and at ease in very different social situations. She was very good at maintaining the other volunteers' momentum and adapting the organisation to changes in external circumstances which directly affected them. She was particularly praised for this by Stacey, the local NHS Health Trainer and former volunteer:

'*she's very organised, very focused, and she's got lots of support. She encourages them all. She leads, I don't know, she leads by example and by praise, she doesn't dictate, she doesn't belittle, and no, she'll just jolly them all along and will make it work. If anything is put in here way, Jill overcomes it*.' [Stacey, Health trainer]

On the other hand Jill did not seem to be driving innovation or growth. She competently maintained the organisation's status quo, however did not have the skills and predispositions to expand their network and promote the organisation amongst potential new collaborators. Changing circumstances and a limit to future funding from their current grant meant that without more proactive leadership the organisation's sustainability was uncertain. Considering their work through a bureaucratic lens may lead to the conclusion that the group is 'messy and unwieldy', like other 'home grown' groups were found to be (Zimmeck, 2000: 27). However well this may have been working for the volunteers themselves, and despite the prevailing optimism within the committee, I would judge that their non-professional image was a potential threat to Overton Wellbeing Group's sustainability in the longer term.

Macmillan and McLaren proposed a useful distinction between "management" and "leadership" in organisations – the former refers to overseeing the implementation of processes and maintaining the organisational status quo, the latter is concerned with change and the need to 'construct a novel strategy' (Macmillan & McLaren, 2012: 4). I found that health professionals and external agencies, despite often valuing the innovative nature of the community organisations' work, assumed that their ways of working and management would be similar to their own. Particularly Health Connections' and Healthy Millborough's external stakeholders expected proficient managers more than passionate and inspiring leaders who were attentive to the communities they work with and were seeking to bring about change. Jochum and Pratten's study evidenced that leaders in third sector organisations could successfully bring together their organisational values and 'managerial values such as accountability, effectiveness and performance' (Jochum & Pratten, 2008: 10) and although

tensions were experienced, the advantages were seen to outweigh them. However my study confirmed that not all leaders are inherently inclined towards a "management" habitus and whether they are perceived as proficient in their role is highly dependent on their social background.

The three organisational leaders: Patricia, Rashid and Jill have had varying life and career trajectories and they inadvertently brought to their work in the organisations a habitus that had been formed by past experiences:

> 'It is their present or past positions in the social structure that biological individuals carry with them, at all times and in all places, in the form of dispositions which are so many marks of *social position*, and hence of the social distance between objective positions' (Bourdieu, 1977: 82)

All social interactions uncover the participants' 'systems of dispositions (...) such as linguistic competence and a cultural competence' (Bourdieu, 1977: 81). Therefore one's social background is manifested through their embodied cultural capital – their habitus (Bourdieu, 1984). Personal traits such as confidence, resilience and trustworthiness are manifested through bodily hexis, the way people physically present themselves, and which can be "decoded" by others. I observed that the managers were fully aware of their peripheral positioning in the health field and that their personal characteristics played some role in shaping relationships with other actors. In fact, all three spoke of strategic "identity management" as a way of advancing their position in the field and decreasing the perceived social distance between them and their stakeholders:

> 'so many reminders of this distance and of the conduct required in order to "keep one's distance" or to manipulate it strategically, whether symbolically or actually, to reduce it (...), increase it or simply maintain it' (Bourdieu, 1977: 82)

However in reality habitus cannot be changed or attained voluntarily in a short period of time. Embodied cultural capital, the dispositions which are ingrained in individuals, is a manifestation of social origin which has accumulated over time, through the process of socialization in the family, interacting with people of a particular social background and through formal education (Bourdieu, 1986). Consequently, the managers' existing predispositions, such as Rashid's discomfort in the company of external stakeholders, will be difficult for them to overcome. Organisational leaders and members who feel "out of place" when representing their organisation externally have found themselves in a particular

predicament; the same predispositions and way of being which allowed them to be at ease when working in the community, were a disadvantage amongst health professionals and local decision-makers.

All three organisations were aiming to strike a balance between maintaining their relatively relaxed and informal working culture and presenting themselves as effective agencies to key stakeholders. They aspired to retain their autonomy in pursuing their organisational aims yet their sustainability was largely dependent on how well they "fit" the model and outcomes desired by commissioners. The two larger organisations had partially adapted to the style of working of other organisations in the health field, an isomorphic tendency that seemed inevitable, but is in stark contrast with the holistic, person-focused approach they preferred. Most of their staff members were drawn to community work, and specifically to working in a community organisation (as opposed to the public or private sector organisations), believing that this would allow them to prioritise creating social value over contractual obligations or commercial value in their work. The organisations' image in the field was largely shaped by the "professionalism" of the organisations' leaders – their habitus which was the embodied form of cultural capital. Other significant forms of capital which may either encourage or deter from further collaboration and were important to organisational sustainability and autonomy will be discussed in the next chapter.

5.3 Entrepreneurial spirit

Community health promotion organisations were working in an increasingly marketised and austere environment and could no longer rely on easily accessible public grants to fund their services. Diversifying income streams required seeking out new financial opportunities and responding to them appropriately – what I would describe as having an "entrepreneurial spirit". This is the third element of organisational culture which I found made an important contribution to organisational sustainability and autonomy. An entrepreneurial approach and practices on one hand allowed organisations to meet expectations in the field, on the other could provide a counterbalance to restrictive service provision contracts. My respondents mentioned three reasons for establishing entrepreneurial practices and these were most strongly considered and acted upon by Health Connections. The first is replacing income that had already been lost with the decreasing resources available from public sources and avoiding the risk of closing down:

> *'But the reality is that they are losing their ground so they are having to do that* [be entrepreneurial]*. Whereas on the whole, a big NHS organisation isn't losing its*

ground, or it's having a cut, but it's not having to actually go out of business. It focuses a manager's mind quite considerably.' [James, Commissioner]

The second reason is building future resilience to mitigate the risks associated with future funding shortages:

'So essentially it's critical to our sustainability to look at diversifying our funding base, so look at not just grant funding, (…), but also looking at individuals, corporate, events, legacies, anything we can to actually bring in more income so that we are less reliant on one source of income. It's absolutely critical to our future. [Kate, Trustee]

The third reason is to increase the organisation's unrestricted funds and improve their ability to respond to diverse needs, including those that are not seen as a funding priority by statutory bodies:

'but it comes down to money, what we can apportion funds to is restrained, and sometimes we see a need, we really want to address that need, but it's slightly out of our post-code area or we can't quite align it to one of our, you know it's a constant process of trying to fit what we can spend the money on (…) you see a new opportunity and the first thing you've got to do is get funding for it.' [Kate, Trustee]

Health Connections and Healthy Millborough both chose to register as companies when establishing as independent organisations, even though at the time they were well supported by statutory funding. At the time of fieldwork Health Connections was slowly building their capacity for generating income; according to their annual report, in the 2013/2014 financial year they had raised 8% of their income through hiring out their bus for outreach work in the community and another 8% of their income through fundraising activities and donations. Healthy Millborough had been running community gyms for several years which had a modest fee for membership and this accounted for 15% of their income in the 2013/2014 financial year, whereas donations made up only 0.4% - they had no established fundraising activities. Gerald, one of the trustees at Healthy Millborough, referred to the organisation as a '*social businesses'.* Both organisations acknowledged that their organisational way of working was becoming increasingly like a social enterprise, however the term was not explicitly used in their publicity materials or in conversation with me. It was perceived to be quite contentious:

> *'My board are very cautious and don't really like the notion of social enterprise so although I present it as a social enterprise (…), I play it low, because people don't necessarily understand and we're not doing that much business at the moment, but I can see that we might well have to, that might be another way that we can get more money in'* [Patricia, Manager]

Their core identity was very firmly rooted in the third sector and I sensed they feared that an entrepreneurial image would suggest profit-making to members of the public. They used the term "charity" as the most accurate description of their organisation:

> *'We're a charity first and foremost, we describe ourselves as a charity in most of our communications because we are generally applying for grant funding or we're looking for service users. Where we use the term social enterprise is for example, if we're talking to an NHS body that is keen on social enterprise'* [Kate, Trustee]

It was clear that they had a sense of the hybrid nature of their organisations and tried, as best as they could, to use it to their advantage.

In contrast, Overton Wellbeing Group had consciously made the decision to not establish as a social enterprise and uphold an informal and volunteer-led model which was very close to the associational "ideal type". Emma who had been supporting them since their beginnings made the following comment on their transition to independence from the city council:

> '*they did look at things like becoming a social enterprise and there is all sorts of schemes available, they could have looked at bidding for other work, there is certainly other work that that the organisation could do, (…) but that really needs to happen from the organisation itself, you can't impose that on them, but that was explored, with them, but they reached the level of commitment* [that they were comfortable with].*'* [Emma, Local authority VCS liaison officer]

The volunteers from Overton Wellbeing Group did not have the capacity to take on more entrepreneurial activities and possibly also did not want to change the organisational ways of working that they were accustomed to. Therefore the remainder of this section will focus on Health Connections and Healthy Millborough who have, at least in their vision and rhetoric, demonstrated some "entrepreneurial spirit".

Health Connections and Healthy Millborough's business activities were of relatively small scope, therefore I found Patricia and Rashid's awareness that some aspects of their

organisations' work had to be business-like very striking. They recognised that being market savvy and devising a business strategy was an essential part of their role. Their entrepreneurial mind-set was demonstrated by the language they used and how they pictured their organisations as ones that have to take risks, prove their innovative capacity and gain influence in the "market" of local community services:

> *'Three letters – USP – unique selling point – what is going to make you different to what is out there already, why do we need you. Cause from a statutory point of view there will be lots of people who do engagement, good or bad, they're out there, what is going to make you different, what is your unique selling point?'*
> [Rashid, Chief officer]

Both managers presented a vision of their organisations growing as entrepreneurial service providers who have business relationships not only with public sector organisations, but also with commercial organisations and other social businesses. They wanted to be seen as capable partners who bring value to their relationships, not just organisations who spend other people's money. The organisations' external stakeholders were therefore often referred to as their as customers who need to be convinced about the value of their services:

> *'Every time we put in for a funding application, every time we meet a potential donor, even every time we meet a GP who might commission us in the future, we're competing against other organisations, and so we have to be able to present ourselves in a way that is not showing off things that aren't worth showing off, but actually highlighting what we can do, what we're good at, how we can help them.'*
> [Kate, Trustee]

They were acutely aware of the fact that in a very competitive environment where finances are tightly controlled their services have to be innovative and cost effective:

> *'when we're looking at trying to meet a need we need to come up with a really good idea that is cost effective, value for money and that is going to meet that need, and it's also based on what people said they want, so you have to really think hard about how you, rather than – got an idea, here's £50k, go and see if it works'*
> [Rashid, Chief officer]

Rashid went quite far in presenting his entrepreneurial ambitions during the interview:

> *'I want to take it up again to that level, I just want to [pause, sigh] I want to expand, my driving force is to get bigger and to get better (…), increase my turnover, increase the size of my team, increase the area of benefit I can have, increase the influence I can have, I don't know. (…) I think we go for everything and try and grow, I don't believe that you can't grow in the circumstances we're in, in the economic climate, I think you can, you just need to find your niche and just be dogged about it really.'* [Rashid, Chief officer]

However Rashid chuckled to himself when afterwards he was telling me about how his staff joke that he should get himself a white cat to stroke, like the super-villain who planned world domination in the James Bond films. I therefore doubt he really saw this as a likely scenario.

Despite the leaders' considerable determination to become increasingly business-like, Health Connections and Healthy Millborough differed considerably in the extent to which the entrepreneurial aspect of their work was embedded throughout the organisation. In Health Connections the organisational strategy was clearly driven by the management team and financial and promotion issues mostly taken care of by the office-based staff. However it appeared from observing the organisation's work and speaking to staff, that the responsibility for finding new income opportunities and building funding relationships was also held by the more senior community workers. This was emphasized in team meetings and away days, one of which got all staff involved in discussions relating to organisational strategy and promotion:

> *'I think everybody has to realise that they have the responsibility for marketing Health Connections and doing elevator pitches around areas that nobody's comfortable in. So if you've never done anything around teeth you have to do it around teeth, or sexual health so that you start talking about aspects that you really aren't comfortable with*.' [Patricia, Manager]

As I found out, entrepreneurial activities had become part of the community workers' remit over the course of several years. They were very conscious of the challenges the organisation faced in terms of sustainability and of the fact that *'we're now in an age where we do have to be making money'* [Emily, Community health worker]. They were encouraged to share responsibility for the financial and managerial aspects of Health Connections' work. Taking ownership of their area of community work motivated staff to use and develop their personal strengths and skills:

> *'I mean we've seen that with Salima* [networker coordinator]*, she's absolutely loved organising the purchasing* [for winter parcels distributed to the elderly]*, she says – I feel like I'm on the 'Apprentice'! How cheap can I get all this for? [laugh] (…) But Salima was the only person I could think of in the organisation who would get a kick out of it and she's loved it. Anybody else – no. I would have hated it! And it's how you build that*.' [Patricia, Manager]

This came surprisingly naturally to the staff who, as part of their work, established new relationships with public sector bodies, other third sector organisations and local businesses and found new ways of delivering services which would prove financially beneficial to the organisation. The "entrepreneurial spirit" permeated through Health Connections and was something the staff actively identified with.

In Healthy Millborough community staff members were aware of tight finances and the need to save money and generate new income, however it was primarily the three managers who searched for new opportunities and managed relationships in the field. Janet, a key partner, commented that doing business with them was not as easy as it could have been:

> '*we do work in slightly different environments and perhaps different cultures, things sometimes don't move along as quickly as we think they should, but I think that is probably a cultural issue*' [Janet, Housing association community projects manager]

Although it was perceived as a difference in organisational cultures between a business and a charity, this mismatch of expectations may also have been the result of the insufficient capacity in Healthy Millborough to manage their workload. It seemed that the organisation wanted to be more entrepreneurial, however was too busy with their day to day activities and possibly lacked the skills and capital to do it, an issue which will be discussed in the next chapter.

Health Connections' and Healthy Millborough's responsiveness and ability to adapt is an aspect of their work which is fundamentally entrepreneurial and was repeatedly highlighted to me by internal and external interviewees. An orientation towards change and constant reflection on their practice was clearly part of their organisational habitus. This is a trait that may be attributed to small businesses which need to respond to a dynamic market, but my respondents also saw it as an inherent characteristic of the community development approach to health promotion:

'as a community development charity you're constantly: opportunity – is it working – yes, is it working – no – do something else, next opportunity… It is very, it's controlled chaos, in a good way. You are constantly responding to things in the community, trying new things, learning from them.' [Kate, Trustee]

Several community workers from both organisations mentioned to me that they routinely critically evaluate their work:

'*I'm sure the people that access the services we deliver go away thinking they have had a really lovely time, whereas we go away thinking – how could we do that differently?*' [Emily, Community health worker]

'We don't say we're perfect, but hopefully we are constantly questioning the way that we work.' [Omar, Community health worker]

They actively seek feedback from service users to improve how services are delivered. A good example was the poster that Kirsty and her colleague put up outside one of Healthy Millborough's community gyms (see photo in Appendix B.9) – I saw that gym members eagerly contributed ideas. This characteristic was equally reflected in how well the organisations identified and reacted to changing local needs and to commissioning requirements:

'if we spot a tricky gap, in a way I see it as a little tug boat next to a big cruise liner – that we can be more adaptable.' [Clare, Community nutrition worker]

The contrast was often drawn between the small community organisations and larger, more bureaucratic organisations, which was acknowledged by Health Connections' NHS commissioner:

'I think Health Connections is much more pro-active, I think that's its big thing. (…) I can go to Health Connections, I can go to Patricia and say – I want you to alter that milestone because we're got this demand coming in. And she will alter it or will have a conversation about altering it, (…) whereas a big NHS organisation will find that really difficult.' [James, Commissioner]

This flexibility is what the organisations presented to funders as a key strength – one that brings together their charity identity and an entrepreneurial viewpoint:

'*What I say to commissioners is – don't take a one size fits all approach. (…) we'll come up with an approach to suit that particular community, but to solve that*

particular problem in another community we'll take a different approach because it is a different group of people, different values.' [Rashid, Chief officer]

This was greatly valued by several of the interviewed funders:

'some of the things that we tried to do with our added value pot don't always fit into the nice little boxes that the statutory agencies want, so actually going to an organisation that's got a little bit more scope, whose got that in-built flexibility, to tailor things to what we need rather than tell us what we can have, that is hugely helpful.' [Janet, Housing association community projects manager]

Overall I observed that being entrepreneurial was to some degree congruent with the organisations' dynamic, adaptable and "made to measure" approach to health promotion. Incorporating flexibility and responsiveness, characteristics of an "individualist" way of life (Hood, 1998), was easy for them as by nature community organisations do not have very formal structures and are not prescriptive. Their ability to maintain this adaptable way of working was only somewhat constrained by their public sector funding arrangements which provided restricted funds.

In conclusion, it is worth examining how the organisations' "entrepreneurial spirit" was in fact embedded in a "reflexive habitus". Sweetman (2009) argues that social fields are increasingly requiring actors to constantly reflect on their identity and practices, generating a reflexive habitus. Community development promotes an ethos of being attentive to and reacting to the needs of service users, thus shaping reflexive practice. Equally, the health field undergoes frequent reforms and imposes ever new requirements which contradict organisational habitus. This compels community organisations to shape their identities and practices in accordance with, or in opposition to, the "rules of the game":

'It is not a transcendent reflexivity however; it is simply a procedural requirement within that field; a necessary form of collective cultural capital, which becomes engrained in individual agency. Thus reflexivity is as much the habitual outcome of field requirements as any other disposition. Reflexivity becomes, in a sense, the very 'feel for the game' that it is initially defined in opposition to.' (Adams, 2006: 515)

This is where two elements of the "hybrid habitus" – the community development ethos and entrepreneurial adaptability, paradoxically come together. I found that the reflexive predisposition was shared in all three organisations and it was particularly noticeable in Health

Connections where the community development and entrepreneurial aspects of the organisation's identity were strongly associated with one another. On the other hand, the three organisations' ability to capitalise effectively on this habitus differed considerably, which once again may be a reflection of their cultural capital:

> 'In short, the art of estimating and seizing chances, the capacity to anticipate the future by a kind of practical induction or even to take a calculated gamble on the possible against the probable, are dispositions that can only be acquired in certain social conditions' (Bourdieu, 1990: 64)

Having a hybrid habitus which incorporates reflexivity was therefore an important factor for the organisations' ability to take advantage of opportunities in the field, and therefore for sustainability, however it was not sufficient on its own. To benefit from hybridity organisations also had to have sufficient capital and be able to make certain compromises, often departing from their preferred ways of working; I will discuss the key risks I identified in the next section.

5.4 The challenges of a hybrid habitus

Overton Wellbeing Group had chosen to avoid taking on a "hybrid identity" by remaining a relatively informal voluntary organisation, however Health Connections' and Healthy Millborough's practices were, to some extent, shaped by a hybrid organisational habitus. They assumed that in current circumstances this improved their organisations' sustainability and autonomy. Nevertheless, sustaining a "professional" image and having an "entrepreneurial spirit" was in many ways challenging for community health promotion organisations – this became very obvious to me in the course of fieldwork. Remaining faithful to their mission and maintaining the community development ethos was considered a priority, however they also had to become more "self-interested" as an organisation. Compromises were made to meet external expectations of "professionalism", negotiate costs and remain competitive. The pressure on staff to deliver "more for less" was an aspect of entrepreneurial culture which not only potentially impacted on the quality of their services, but also significantly decreased employee work satisfaction.

The first area of tension was between the need to be "professional" and effective, a prerequisite for obtaining public sector funding, and continuing to deliver high quality and distinctive services which correspond with the organisations' ethos and mission. Given that the organisations had a preference for building long-term and largely unstructured relationships with service users, achieving short-term, measurable outcomes and working in the most cost-

effective way was fairly problematic for them. Chandra, a Healthy Millborough community worker argued that

> '*it will take time to change the way people think. We're not going to change it overnight*.' [Chandra, Community health worker,]

Their preferred way of working with service users was based on informal social interactions and the common enjoyment of activities. The community workers don't see their dealings with service users as time-restricted:

> '*Cause we're more relaxed and they're more relaxed, we're not on a time scale, we have 2 hours to chat to them, whereas the doctor has set appointments*.' [Nicky, Community health worker]

This conflicted with the need to be business-like and efficient – this was particularly articulated by staff at Health Connections when discussing organisational identity at the workshop I organised for them:

> '*it's not about money-making, not a business, it's about community spirit and working together, and putting things together and supporting each other*.' [Emily, Community health worker]

In my interviews some concern was also expressed about "mission drift"; this was associated with the organisations taking on work that was outside their remit and beyond their immediate scope of practice because they needed the funding to remain sustainable. David, a trustee at Healthy Millborough and director at the local housing association commented on the fact that the organisation has responded to radically shrinking local resources for health promotion by seeking new sources of income:

> '*I think they have moved from very much, or are starting to move from projects that clearly had a health label to it, so smoking cessation, to even something like taking on the trainees last year from the future jobs fund (…) that has been the biggest shift to maybe Rashid going – if we go for that project and if we put in a bid for that work, yes there is a health benefit even if it is indirect. (…) the pure health ones are still interesting, it's not a shift away from that, that's the core. (…) so just going for those projects alone wouldn't make the charity sustainable, so we've got to look at other avenues as well*.' [David, Trustee]

He explained that this had been a gradual process and that the organisation's leadership felt that despite the associated risks, changes were inevitable:

> *'I don't think it's been a clear decision and a clear change of direction (…) I think it's just evolved over the last 12 months really. (…) there needs to be some control so that you don't spread your wings too wide, but by the same token, just not going for those things in the current economic climate wouldn't have been the right solution, you've got to work from your funding streams.*' [David, Trustee]

Likewise concerns were raised about Health Connections taking on numerous and diverse projects to safeguard financial stability and whether this would damage the quality of their work, both externally by Helen, the health partnership manager at Health Connections' local CVS and Clare, Health Connections' nutrition worker:

> '*there is always the danger with organisations that you don't become a victim of your own success, as long as they keep true to what they deliver and the standard of what they deliver, not lose the quality of what you deliver because you are too busy trying to survive*.' [Helen, Health Partnership manager]

> *'I do wonder sometimes whether our strengths may become our weaknesses if we're not careful, in that we are very flexible, we do an awful lot of things, we've already got to the point where our enthusiasm went before us, (...) too successful for our own good (...) Two years ago there was time, there was lull, there was time to do the creativity bit, but we no longer have the time to develop new resources or whatever it might be'* [Clare, Community nutrition worker]

There was an additional risk associated with the perceived "effectiveness" of Health Connections in securing local funding – alienation from other local partners. Being seen to absorb a high proportion of project funding designated for third sector organisations in the area could have made them unwelcome competition for others:

> *'I think their large size can work against them as well (…) they're sort of towering over a lot of the smaller organisations, (…) Health Connections are incredibly cash hungry, (…) if they are just seen as hoovering up all the resources in an area at the cost of everyone else, then they're going to become unpopular, (…) you reach a point when you're successful, you're big, and people feel they've supported you to get there, but just as easily shoot you down [laugh].'* [Mike, Community centre manager]

I mentioned this risk associated with being a "big fish in a small pond'" when feeding back my findings to Health Connections' staff. In response Patricia laughed and commented: *'I don't mind being a whale – just gently pushing someone to the side by accident'*. She explained that there were cases where they took over services which were run very badly by another organisation, and that '*if we can meet a need that isn't being met there, then that's part of our mission and we will go and do it'*. This is an interesting interpretation of market principles which in this case outweigh collaborative solidarity – if another organisation's services are not adequate, then for the good of the service users the services should be delivered by another organisations who will do it better.

Secondly, there was noticeable tension between the people-centred approach and relationship-building focus of the community health workers and the external pressure to achieve particular outcomes. Community workers make an effort to appear approachable to service users, particularly not to put themselves in an authoritative role:

> '*it is about taking alcohol advice, it's about taking you sexual health advice into the space where young people would access, going in with beer goggles and driving around little trucks, that makes it fun but the message then is serious and can have an impact*.' [Patricia, Manager]

My experience of participating in the organisations' various activities confirmed this. I may have, at first, felt out of place when I sat down in a circle of chair exercise participants, all of whom were well over 50 years old and had mobility problems. Soon it turned out that the exercises were quite a mental workout and my coordination failed much more often than the other, more experienced, participants'. So they teased me about it in a good-humoured way and at one point I laughed so hard that I cried. The atmosphere was spontaneous and high-spirited, the instructor introduced several simple but very silly games and it was, I noted, like playing with a group of children. Later in an interview Jill told me that this is how the chair exercise sessions normally happen:

> '*You saw this afternoon how fun it* [chair exercise class] *was,* [exercise instructors] *work hard to make it fun. (…) Oh sometimes it just gets hysterical, (…) and* [exercise instructors] *understand that that is important and they are so good, they make it fun, they put everything into it.*' [Jill, Chair]

The general working atmosphere in the organisations could be described as "light-hearted"; staff members clearly found it important to enjoy their work:

'*And it's kind of odd, cause I look at it and I don't really work, I kind of play most of the time, (…), so as you saw in the cooking, we're just playing around, chopping stuff up, and chatting and having a brew. [lowered voice] It's not like work really, I can't believe people pay me to do this [laugh].*' [Kirsty, Community Dietician]

There was a common belief that delivering services in a fun and relaxed way ultimately made them more effective, as expressed by Ricardo who ran a small youth charity: *'Nobody wants to be lectured, but if you make it fun then people remember that*.' [Ricardo]. This approach is contradictory to the structured, efficiency-orientated approach which is increasingly required by public sector commissioners. I would judge that the relaxed and person-focused way of working certainly benefited the service users, but did not necessarily coincide with efficient and focused use of time. The community workers had also found it difficult to set personal boundaries between the support they offer in their professional role and the help they offer beyond that, which further exacerbated the pressure of increased workloads:

'you're struggling with something, and usually the dilemma is do I take a bit of work on, the extra bit squeezed in – that's what Health Connections is really good at (...) I read that our delivery has gone up by 29% but it was like, why is that a good thing? On one level it's brilliant, on another level, we are driving each other so much more, that we're all slowly starting to topple over.' [Clare, Community nutrition worker]

Their strong personal commitment to helping people in need was time consuming and sometimes quite draining. Many of them admitted that, despite their better judgement, they gave up their private time to "go the extra mile" for their service users and then felt overburdened. This was first raised as an issue by Clare, a nutrition worker at Health Connections. She told me how she had spent one and a half hours of her private time the previous day helping a man, who she saw at a group she runs, book an emergency NHS dental appointment. He was suffering severe toothache but had poor English, little experience in accessing healthcare and did not know where to turn for help. The need to be able to strike a balance in this came up in during the staff workshop at Health Connections:

Emily: *sometimes I feel like we're putting pressure on ourselves, regardless whether the pressure is coming from management or from above, I know I put a lot of pressure on myself to deliver, and I go out of my way, and sometimes you just think – I don't need to, but it just happens naturally*

Clare: *the problem with people here is we, it's we're all passionate about it and I think you've got to the point when we're all beginning to say no, because we're all getting a bit stressed out.*

Finally, there were tensions between the organisations being increasingly business-orientated and employee work satisfaction. I found that in these organisations it is strongly associated with the quality of relationships staff members have with service users and their colleagues. The general working culture in the organisations was relaxed and the staff members valued maintaining good professional and personal relationships with each other. They attached importance to eating lunch together, having spontaneous work-related or personal conversations during the day and building a strong team spirit. This kind of sociable atmosphere was still observable in Healthy Millborough's office despite the staff's perception of increased workload and "being very busy". This was noticeably different in Health Connections where staff members were mostly preoccupied with their work, spoke to others when it was required by the task they were working on and ate their lunches whilst continuing work at their desk.

Valuing "down time" in the office

The Health Connections' office is open plan (see photo in Appendix B.1) so the same space is shared by everyone. On one hand it can feel very busy at times as phones are ringing and people speak to each other from their desks across the room. On the other, it can be very quiet when staff are at their desks very focused on their computer screens. Most staff members are part-time and the community workers spend a significant part of their time out in the community, therefore there is a high turnover in the office in the course of the day and week.

'*gosh [pause] if I could change one thing [pause] I would have more, I would have more social time with my colleagues. Cause we all work part-time and a lot of us are in on different days, when we are in, we're all so busy, we don't have enough time when we just sit down at a desk and have a giggle, even for 5 minutes, I don't tend to do that and I haven't worked in that environment before. So I don't necessarily, I don't want to know really, really personal things about people, but I don't really know what they're doing, what is going on in their lives, except if you really befriend someone, like I don't know if Sharina is alright really, she doesn't know if I'm alright really. I know that she's doing a great job, but her house could have fallen down last night and I wouldn't know – do you know what I mean?*' [Nicky, Community health worker]

The staff workshop I organised gave the community health workers in Health Connections the opportunity to have some "down time" together and it was obvious how much they appreciated it. It allowed them to discover that each of them had experienced increased work pressure and felt frustrated with the increasingly limited support they can offer each other. Here is part of their conversation I recorded:

Rahim: *we need to talk about it more that what we're doing and how far we are going, sometimes you know what you are doing, but you come to tell somebody – I'm doing this you know, I'm struggling with this, or I don't know if I'm doing too much or not*

Emily: *you mean taking the opportunity to do that?*

Rahim*: Just discussing it, just discussing with somebody else, obviously you have formal supervision, but even across the office just nattering sometimes (…)*

Clare: *Actually I have more of those conversations with Sharina and Mandy because I have natural reasons in the office, getting money off of them, or getting flyers or whatever, then*

with you lot, because we're sitting there and we're all trying to get on with our work, we actually don't do that for each other.

Nicky: *I remember saying this to you ages ago, I said, I never worked anywhere so quiet, and I find it, sort of, it's hard to voice up, because people come in, people work part time, everyone works part time, so when they're in, it's nose to the grindstone*. (…)

All: *yeah*

Nicky: *That very rarely happens here, so when you do have a problem, you think* [whisper] *it's very quiet*

All: *yeah*

Rahim: *And that's when it becomes kind of difficult, because you just need to connect with your environment sometimes, you just need that…*

Clare: *you see, I've always tried when I'm in the office to take a lunch break, other people don't and our delivery time is often around that time, so I have a lunch break and I go and sit over there* [staff social corner], *and it's almost never that anybody comes and has a lunch break too.*

Emily: *I'm guilty of that, in fact it usually takes me an hour to eat my sandwich.*

Nicky: *And you all sit and moan that you're all guilty about that instead of doing it*'

To some degree community workers were starting to feel overwhelmed by the expectations that they placed on themselves, which were exacerbated by the expectation of funders that they will "deliver more for less". Knight and Robson (2007) found that in voluntary and community sector organisations staff members felt that their passion is being exploited, particularly if their pay was lower than their qualifications would merit:

> 'Most often, this was a form of self-exploitation, though there were some cases where people felt exploited by their employers too. In one case, staff said that they often worked over and above the hours they were supposed to, to the point where it impinged upon personal lives' (Knight & Robson, 2007: 50)

The community workers in all three organisations indicated that to some degree they were struggling to meet the conflicting demands of their role – demands that come from their own

habitus and ethos, and obligations set by other players in the field. This finding resonates with Buckingham's conclusions relating to the 'middle ground' position of 'cautious contractors' in homelessness services (Buckingham, 2011). However, some of these expectations will always be conflicted, and some of the tensions have highlighted how insufficient organisational capital inhibits the organisations' ability to maintain its preferred ways of working whilst remaining sustainable.

5.5 Conclusion

In this chapter I have demonstrated how community health promotion organisations adopt certain dispositions and practices to facilitate building relationships both in the disadvantaged communities they serve and with key local stakeholders. In the current austere and gradually more marketised environment they are increasingly compelled to present a "professional" image to gain the confidence of their external stakeholders and to employ entrepreneurial strategies to generate additional income. This means they are combining their community development ethos with practices that are based on principles from the public and private sectors, i.e. rooted different in different "ways of life" leading to a "hybrid habitus". This chapter demonstrates that reconciling organisational preferences and predispositions rooted in their community development ethos with the external expectations of professionalism and entrepreneurialism is problematic for community health promotion organisations.

I found both similarities and differences in the three organisations' habitus. They were very similar in their values and beliefs relating to health and health promotion and in the personal predispositions they applied in their work – the core elements of their third sector identity. The organisations differed significantly in their ability to successfully implement ways of working which were professional and entrepreneurial. I would conclude that this variation was associated with differences in the background and skills of the people involved, which in turn affected organisational capacity and cultural capital – these will be discussed in more depth in the following chapter. These disparities, particularly the case of Overton Wellbeing Group which "opted out" of hybridisation, demonstrate that not all organisations are equally able to manage a "hybrid habitus".

This chapter also shows that there are several areas of tension associated with hybridity which were most evident in Health Connections – the organisation that had been relatively successful in implementing this model of working. Fundamentally, I identified a clear conflict along the lines of the grid and group dimensions of Hood's (1998) conceptualisation of the ways of working in different sectors. Following the "Egalitarian Way", community health promotion

organisations are not rule-bound whilst promoting group cohesiveness i.e. prioritising relationship building and wide participation in decision-making. This puts them at odds with public sector organisations which are inclined to prioritise rules and oversight according to the "Hierarchist Way" and with the business model where social relationships are disregarded according to the "Individualist Way". These "ways of life" are rooted in very different habitus and it is difficult to see how organisations could sustain a viable "hybrid habitus" in the longer term. It is therefore crucial that organisational culture is taken into account when considering hybridisation as a resilience strategy for community organisations.

Conversely, adapting the theory of institutional logics, Skelcher and Smith argue that in hybrid organisations actors find different ways of negotiating the contradictory "normative frames"[7] from different sectors. To achieve this, meanings and identities are creatively reconstructed both at an organisational level and at an individual level to alter the 'symbolic and material elements that structure organisational legitimacy and actor identities' (Skelcher & Smith, 2014: 1). Skelcher and Smith found that organisations have various ways of accommodating (or not) these disparities distinguish five types of third sector hybrid organisation basing on their way of achieving this:

- segmented - functions oriented to different logics are compartmentalized within the organization,
- segregated - functions oriented to different logics are compartmentalized into separate but associated organizations,
- assimilated - the core logic adopts some of the practices and symbols of a new logic,
- blended - synergistic incorporation of elements of existing logics into new and contextually specific logic and
- blocked – organizational dysfunction arising from inability to resolve tensions between competing logics (Skelcher & Smith, 2014: 8).

From my observations, Healthy Millborough and Health Connections were closest to the assimilated hybrid type: trying to meet the expectations of external stakeholders to take on new ways of working whilst remaining dedicated to their community development ethos and third sector identity:

[7] 'socially constructed, historical patterns of cultural symbols and material practices, assumptions, values and beliefs by which individuals produce and reproduce their material subsistence, organize time and space, and provide meaning to their daily activity' (Thornton et al. 2012: 51 in: Skelcher & Smith, 2014: 5)

> ‘In these cases, the organization reflects the expectations of the new logic in terms of its structure, symbols, and language, but in its day-to-day practice continues to operate in line with its institutional origins.’ (Skelcher & Smith, 2014: 10)

Health Connections were also noticeably moving towards blended hybridity, particularly through their drive to be more entrepreneurial and seek out local sponsorship for some of their activities. Nevertheless, despite these strategies for managing hybridity, it remained problematic for community health promotion organisations due to their small size and limited resources. This study indicates that incorporating practices that are rooted in different “ways of life” requires organisations to have considerable capacity and capital. The following chapter will further investigate organisational capital, the resources that support community organisations in negotiating their positioning in their local health fields.

Chapter 6

Organisational capital: having the capacity to act

"Organisational capital" is the pool of non-material resources available to organisations which are potentially useful for gaining, maintaining or improving their positioning in the field (Bourdieu & Wacquant, 1992). Capital is present in community organisations on two levels: the organisational level and the individual capital of people involved which is aggregated within the organisation. Organisations accumulate capital, for example, through relationships formed between the organisation and other local agencies or through the recognition of the organisation's work by external stakeholders. They also benefit from the capital held individually by their staff, trustees and volunteers, whether it is their particular skill-set or personal connections. Guided by Bourdieu's conceptualisation of capital, in this chapter I will discuss four different forms of capital: time and operational capital – not a bourdieusian concept but a critical resource for community organisations, social capital – the advantages associated with having relationships with people and other organisations (Bourdieu, 1986), cultural capital – access to esteemed material and abstract goods (Bourdieu, 1986) and finally symbolic capital – the status associated with having the forms of capital valued in a given field (Bourdieu & Wacquant, 1992). These forms of capital are important for organisations to be recognised as valuable players and have a strong position in the health field.

Community health promotion organisations are situated in local health fields where public sector bodies and medical professionals are well-established in their positions of power. They set the "rules of the game" about how health is defined and how resources are distributed, but also which forms of capital give other actors legitimacy in the field:

> '[they] gain thereby the capacity to determine, within the field in question, the relative values of all other kinds of resources (…) within the overall distribution of capital that constitutes the state of power relations within that field; they gain, moreover, the capacity to produce the recognition of the legitimacy of this distribution among the other contending parties.' (Emirbayer & Johnson, 2008: 13)

Community organisations are set up to fulfil a particular mission, usually to fill a perceived gap between the needs in a local area and the services provided by public sector organisations and businesses. They typically have less financial resources and local influence, however they contribute more intangible social resources, which are particularly valuable in areas of

deprivation where there is limited civic engagement. The studied organisations particularly valued having the time to offer holistic support to service users and the skills to establish strong relationships and the trust of communities. These are not necessarily the forms of capital which are a recognised as important by key actors in the health field, therefore organisations seek to gain other forms of capital which are more desirable; for example, social connections with influential agents in the field, marketing skills and formal recognition of their quality of work.

The studied organisations were working in an unfavourable environment and their organisational habitus was largely not very compatible with their fields, therefore I will argue that their organisational capital played a deciding role in supporting their autonomy and sustainability. In this chapter I will compare the significant forms of capital held (or not) in the three case study organisations and discuss their value in the local health field.

6.1 Time and operational capacity

Staffing and availability of time to perform essential and optional tasks was a key issue mentioned by my respondents when discussing their organisation's ability to remain sustainable and maintaining autonomy. Despite size differences, varying organisational workloads and ways of working, respondents from all three organisations indicated they were struggling to cope with the increasing demands on their time.

Health Connections is the largest of the studied organisations and had been expanding since it became independent. It was able to make a significant impact locally thanks to its size, being deemed *'big enough to count'* [Mike, Community centre manager], and its ability to *'stay on people's agendas'* [Helen, Health Partnership manager]. The organisation employs a part-time staff member who is responsible for communication and promoting the organisation through multiple channels, amongst others, a frequently updated website, Twitter, quarterly newsletters for service users, commissioners and other local stakeholders and briefings from local health consultations. They also managed to spread the extra workload resulting from increased engagement with external stakeholders:

> '*I got elected onto the Health and Wellbeing board which is great, but it's a lot more work that I have to do which means that some of what I have been doing has been delegated, so the organisation is being stretched*' [Patricia, Manager]

The main concern of staff there was that expectations of what the organisation could deliver had increased disproportionately compared to staff capacity. This was perceived to have

caused a demand for more "efficient" work which left little time for service development and value-added work. There was therefore growing concern for the quality of their community work. Clare, Health Connections' nutrition worker expressed her concerns quite forcefully:

> *'suddenly it's all got so busy that it's quantity not quality (…) I do most of the oral health work, and two years ago I had time to develop resources for it, including marrying together nutrition and oral health advice and it became a little booklet with recipes and eating suggestions and various things, (…) we've got a dentist who is trying to get the National Dental Association to fund a little booklet that has all that in it and more. And that's 2 years later, but now my question is, would I ever have the time to create something like that now, and the answer would be – no [laugh]. (…) suddenly there is no extra, two years ago there was time, there was lull, there was time to do the creativity bit, but we no longer have the time to develop new resources or whatever it might be'* [Clare, Community nutrition worker]

This was echoed by other interviewees who noted that the organisation was taking on more work to gain much needed income, but these contracts did not budget for time spent by staff creating the extra value in communities. There was growing concern that the organisation was sacrificing the quality of their work to deliver more "outputs' with the same staff capacity.

Healthy Millborough initially grew as an organisation after becoming independent, however it lost nearly all its NHS and council funding in 2011 leaving it only with lottery funding to cover core costs. It therefore laid off several members of staff in the year prior to my visits and the remaining eight staff members reduced their working hours and took a small pay cut to save a post. This, together with significant uncertainty regarding the availability of funds to maintain staffing levels in the next year, had a noticeable adverse impact on staff morale in Healthy Millborough. When asked about something they would like to change for the better, they typically wanted more stability as expressed by Chandra, a community worker:

> *'To be able, (pause) being secure for at least another couple years, to know that the financial security is there for us, to carry on. It will be a shame, I don't think the charity will fold, but it would be a shame to lose more staff, to lose those people's ability, because once you lose those people it is difficult to gain that person, that similar sort of person that has that multi-talent say, and to know that we're all*

going to be secure for another year and to know what we are doing." [Chandra, Community health worker]

Funding for health promotion projects in the community had become not only more scarce, but also increasingly short-term with projects lasting a couple of months at a time. This made it difficult to make a lasting difference in communities and gave staff members a sense of insecurity about their employment. There was a very tangible feeling of uncertainty of the organisation's future and of struggling to maintain core services with less staff. The management team was under considerable pressure to gain new sources of income which they found to be very time consuming:

'Bureaucracy at commissioning level – there is an issue of proportionality which I think in terms of the hoops that we have to jump through for public sector funding, (…). And a lot of it is just tick boxes. But I haven't got a procurement arm of my organisation or a policy arm to do that for me, I got myself and two managers.' [Rashid, Chief officer]

Healthy Millborough seemed to have insufficient capacity to respond to funding bids and be more proactive in promoting and developing the organisation to generate new income streams.

Multi-tasking

The team at Healthy Millborough is relatively small and is stretched in terms of capacity. Most staff members regularly perform duties which are outside their core role. Rashid, the organisation's manager, remains very "hands on" and involved in the community work, and during one of my visits, I heard him volunteering to drive the mobile food coop van for a day when none of the organisation's volunteers were available to do this. Omar, whose primary responsibility is delivering community development projects, also has taken on managing the ongoing maintenance of the van and most of the organisation's promotional work:

'*my background is in media, so whether it is in graphic design, or video or photography (…), they allow me to utilise some of those skills (…) it gives me an opportunity to do something that I like while also working with the young people*' [Omar, Community health worker]

The organisation had taken on a variety of short-term projects which means staff members are often changing their area of work and simultaneously running several small projects:

'*Cause at the moment we are getting a lot of short-term contracts (…) you can't get your teeth into it and really make a difference.*' [Chandra, Community health worker]

The four community workers shared an office with the administrator and they jointly undertook many tasks. Everyone answered the office phone responding to a variety of queries as the administrator worked part-time, and they have a rota for gym cleaning as there were

no additional funds to pay an external provider for this. Working in the office they altered between being very quiet and focused on their particular task and periods of talking across the room, discussing their work and personal matters in a lively fashion. Whilst each community project had a responsible lead worker, the team members commented that often everyone just "mucks in" to get work done. I observed that as a result staff members dedicated time to a variety of tasks and had frequent distractions during the day. Overall, the staff found it hard to manage their time well as a result of an overload of duties and their preferred collaborative working style making them less effective.

The organisation was not managing to maintain an up to date website despite understanding the benefits of a good quality web presence, a symptom of insufficient capacity. At the time of research, the organisation's website had been out of date for almost 3 years and a new one "due very soon". This new website did eventually go live many months after I finished fieldwork, however since then has not been not been regularly updated. The management team and community staff were aware of the value of communication with stakeholders and keen to use social media to promote their work, however no one in the organisation held key responsibility for external communication and it was rarely treated as a priority. Rashid explained that their external promotion work is restricted by their capacity: '*we don't do enough because we are too busy trying to stay alive'.* I got a very strong impression that as an organisation they really were in "survival mode", working hard to carry out essential tasks and "firefight" as described by Gerald, a trustee and local CVS director:

> *'um, sometimes you get the impression that they are firefighting occasionally, that with the resources they are probably overstretching themselves, (…) so we have all*

sorts of discussions at the board that they manage their time effectively and don't do too much else' [Gerald, Trustee]

In this case though I observed not only a shortage of capacity but also what I could define as a shortage of "organisational competence", a term used by Chapman et al. to describe an organisation that in times of change is able to 'marshal its assets to work efficiently: they are, in short, well organised' (Chapman et al., 2012:19). Consequently the organisation did not do the extra things that could help them lift themselves back up again. Healthy Millborough's decreased capacity was a limitation in terms of the organisation's ability to become more sustainable in the long term.

Overton Wellbeing Group was established as a volunteer-led support arm of a local authority project which was led by council community workers. In March 2012, when the local authority withdrew its remaining part-time community worker from that project, a committee of 12 volunteers took over full administration of all the delivered activities. A local health trainer, Stacey, who collaborates with them described them as *'self-sufficient'* and *'capable'* and they equally take great pride in being able to achieve this:

'*I think it's dedication of people who are in it, without them, if we didn't have that enthusiasm, I don't think it would work, I really don't. Everyone is keen to make it as successful as possible, and I think that's it.'* [Pam, Deputy chair]

Time was however indicated as a key barrier in the organisation's further development. The regular activities were organised by a core group of four volunteers, all nearing or past retirement age, and they all considered it to be a significant commitment:

'when there is a committee meeting on a Monday morning I don't book in doctor's appointments or anything, everything is planned around it. (…) the thing is what people say, that voluntary work takes your life over, and you sort of get roped into events and before long, I think some days – oh, just can't be bothered. And the children had said to me – well give it up then. And I say – no, I can't give it up.' [Pam, Deputy chair]

They all had their own limitations due to health issues that they are dealing with; Sharon who had been recovering physically and psychologically from a stroke spoke of the importance of pacing herself when taking on responsibilities:

> *'don't put yourself out too much, because otherwise you will be inundated and your time won't be your own, because you need your own time. On Tuesday is Tai-chi, but if I can't make it for whatever reason or I'm a bit down, then I call on Pam to take the class, or Jill would do it'* [Sharon, Tai-Chi coordinator]

The organisation was very restricted in how much it can develop; as a committee the volunteers decided that they are not interested in setting it up as a formally registered charity or working as a social enterprise. Emma, the VCS liaison officer in the city council, emphasised that it was quite remarkable that the volunteers managed to continue the organisation's work at all:

> '*I was always encouraging people to decide what is it that you want to do, because they could do almost anything, they had to decide how many hours they want to put in, they do enjoy volunteering, it is always difficult, I've sat in many meetings, I'm getting paid they aren't, we are all working hard, and it is interesting people will work hard in their own communities'* [Emma, Local authority VCS liaison officer]

The existing paperwork and formal arrangements were already perceived as quite a burden. The committee members were all drawn to working directly with members of the community, not performing managerial and administrative duties and searching for funding. South et al. (2013) argue that community-led action needs to be backed by professionals who are better placed to manage formal issues and applying for funding. Particularly Jill, who took on the role of chair, mentioned several times that it feels '*like a job'* in terms of time and level of obligation:

> *'now as Sue, the* [council employed] *project leader, her job role has changed, she trained me up from January to March to more or less take over from her, so I'm effectively doing the work Sue did, a smaller version if you like but it's still basically what she did. So I've taken over and like I said, you've got no time really for anything else (…) I'm working from home now so I'm putting in a lot of hours on paperwork and telephone calls.'* [Jill, Chair]

Other members of the committee were not disposed to take on any administrative duties beyond coordinating the weekly activity groups and they were struggling to recruit new volunteers. The existing group of volunteers seemed to be at the limit of what they were able

to manage; it was difficult to see how they could, for example, develop their services or find new income streams after their current funding ran out without significant external support.

"Staying alive" was the prime focus of all the organisations and capacity was identified across all three as being, to a different extent, partially at the root of problems with obtaining funding to cover core costs and ability to take on more volunteers. Comparing the three organisations it is clear that although they all perceived themselves to be stretched in terms of capacity, the smaller they were, the harder it was to go beyond delivering existing services and develop the organisation. Consequently their response to threats to their sustainability differed significantly. I also found that their capacity, to some degree, restricted their ability to accumulate social, cultural and symbolic capital. I will discuss the significance of these forms of capital in the subsequent sections of the chapter.

6.2 Social capital

A broad network of relationships, within and outside the communities they work with, is a significant resource for small community organisations. These relationships are developed by the organisation through its work as well as individually by its staff, trustees and volunteers. Bourdieu's (1986) theory of social capital indicates that organisations could benefit also from the capital held by the people and organisations they are connected with therefore both the size and "quality" of their networks is important. The value of the organisations' social capital is dependent on how many actors they are connected to in the health field, but also how big the pool of resources, both tangible and intangible, these actors have access to, i.e. to what extent are these connections potentially useful in improving the organisations' positioning in the field. Despite existing formal criteria and processes in commissioning, it was recognised that a good relationship with decision-makers can directly and indirectly influence an organisation's chances of success. Health Connection's trustee Steve considered there to be a direct connection between relationships and successful bids for funding:

> *'I think the other side of it is relationship building, what might be called the commissioning business end of it, not just to be a bidder writing bidding papers, I think the key element of that, as much as what you put on paper in negotiating money, is the relationship with that person, having developed relationships.'*
> [Steve, Trustee]

Similarly, it was believed that a collaborative relationship with statutory bodies and other community organisations could be beneficial in widening the organisations' influence and improving their positioning in the local health system. The social capital of the three studied

organisations was very different and largely depended on the resources of the individuals involved and attributes of their organisational environment.

Below I have inserted diagrams that portray the organisations' key external relationships that I had been made aware of in the course of my research. The diagrams differentiate between:

- the organisations' long-term funding bodies,
- project delivery partners and regular collaborators,
- organisations that they have personal connections with, but have no established collaboration and
- organisations with which they have failed to establish a working relationship with.

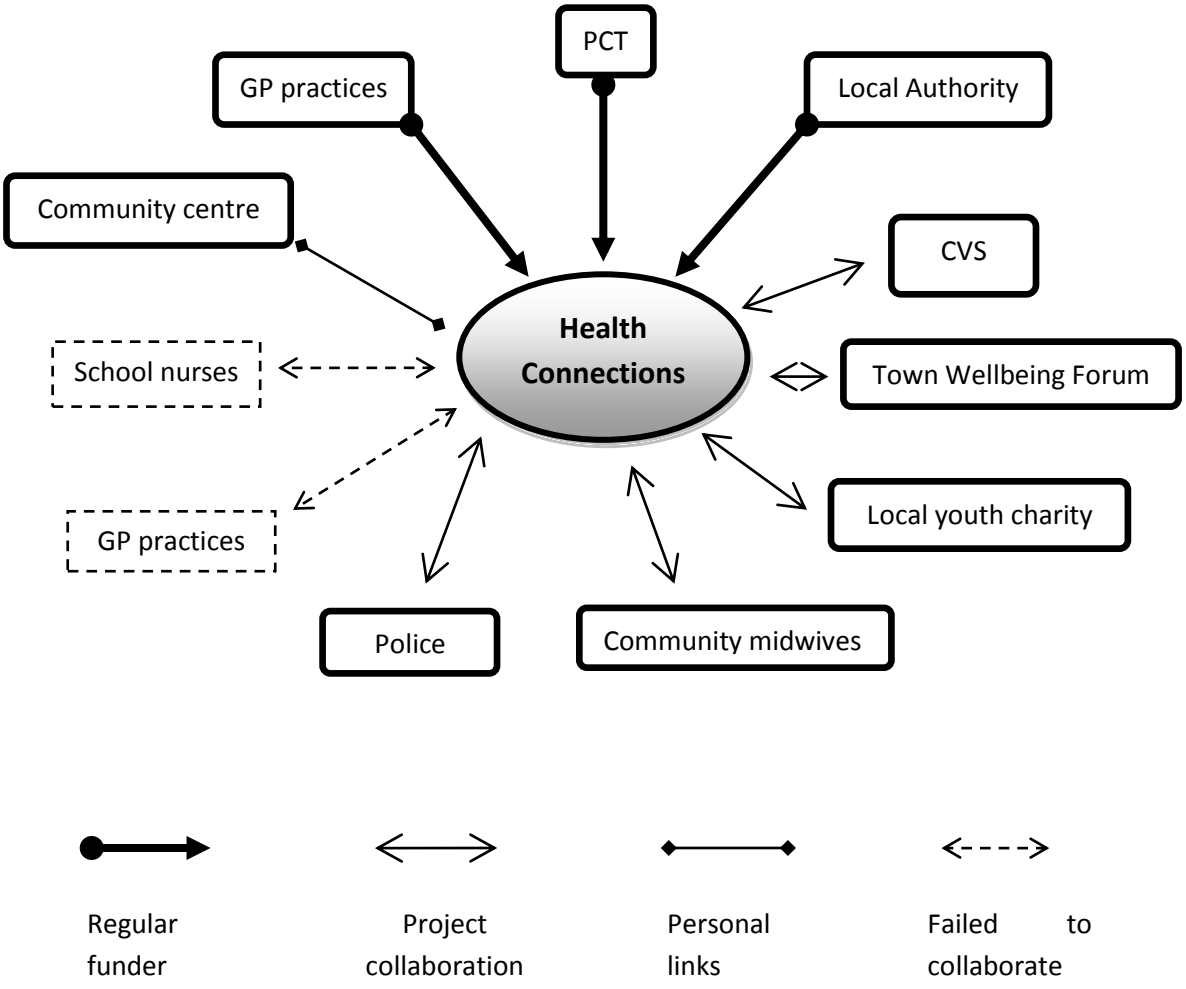


Figure 5: Health Connections' external relationships

Health Connections had considerable funding from the local PCT, social services and several GP practices. Although this funding was uncertain and decreasing, the organisation maintained a

good working relationship with public sector commissioners who remained enthusiastic about their work. The organisation believed that it is these relationships that make them credible collaborators for other public services which they worked on projects with, for example community midwives and local police officers. There were several other like-minded community organisations working in the area. Health Connections' comparatively large size and prominent status meant that they were considered valuable partners, therefore their network expanded basing on their reputation. Ricardo, who managed a local youth charity and had recently started building a closer working relationship with Health Connections, emphasised the mutual benefits:

> '*The other problem that we're all going to be facing is the diminished funding, that's why we go back to this idea of shared bids, because then we can not only utilise each other's skills, but professional ranges, and assets and resources, buildings even, we can then share the funding streams in terms of development of projects and help each other in our targets as well.*' [Ricardo]

Health Connections also had a reputation for bringing organisations together through organising local health-related collaborative groups and events involving a broad range of participants.

> '*Something else that we do is we bring partners together, we've been responsible for the last 2-3 years for bringing partners across [town] together to think about what are the health problems and so we have our Creative Health Solutions, we have two of those a year looking at different particular issues that are of concern to the organisations of [town] or to the people of [town] and then how can we work together around them and then what are the solutions that we can share together*' [Patricia, Manager]

This is a conscious strategy of positioning the organisation in the centre of a network of statutory and voluntary organisations which work in the area. They believed it benefited local communities, but also allowed the organisation to enter into relationships with key local stakeholders. The organisation also made considerable efforts to establish collaboration with health professionals and, for example, has done so successfully (after a long "negotiation" period) with local community midwives. Julia, the manager of a GP practice which supports the organisation, confirmed that they viewed Health Connections as a valuable partner:

> '*Health Connections is a good link for us because they set up the meeting with the council, as a very busy practice, we wouldn't be thinking on the periphery – oh let's get in touch with* [unclear]. *This area is suffering from deprivation, we wouldn't do that, but Health Connections has actually intervened and set that up so we're actually at particular areas within our practice boundary with them to see how these problems can be tackled really.*' [Julia, GP practice manager]

The doctors in the practice had a good understanding of the organisation's role in the community and often referred patients who could benefit from social support. Health Connections also grew their social capital by inviting trustees who were healthcare professionals or had valuable local connections in the health service:

> '*we are now going to be missing a real hands-on, practical nurse type person* [on the board] *and we've been working with Rosemary for a long time at [antenatal group], she's been the midwife so I thought she would be ideal so we asked her and she said yes. So that was easy!*' [Patricia, Manager]

This allowed the organisation to have better insight into local policy, gain credibility and open new potential opportunities for collaborative working, increasing its cultural and symbolic capital. The case of Health Connections demonstrated that organisations that have significant social capital can relatively easily multiply it and convert it into other forms of capital.

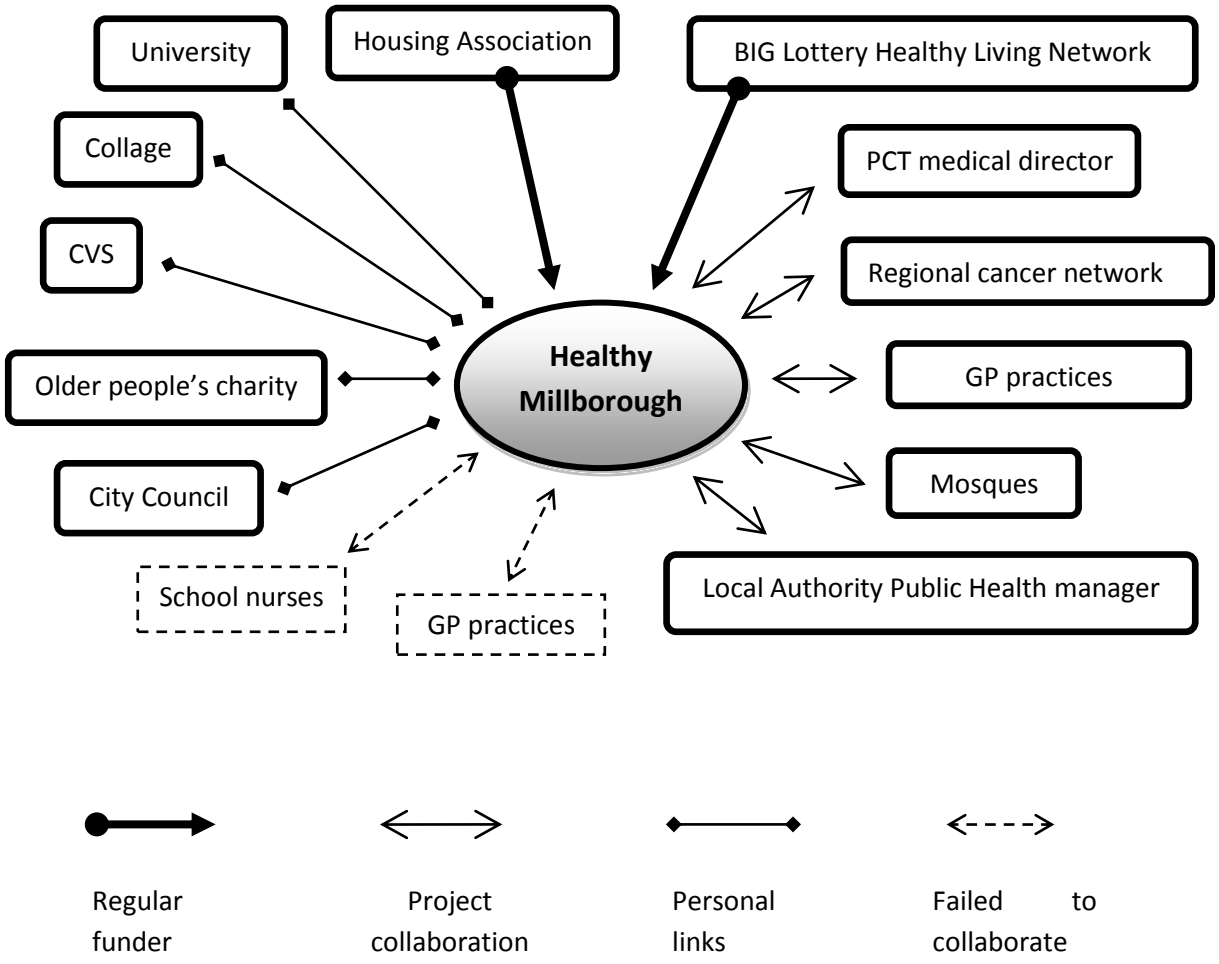


Figure 6: Healthy Millborough's external relationships

Healthy Millborough relied quite heavily on their close network of contacts and collaborating organisations to promote their work and gain funding. Having started off as a joint project between the local council and PCT, they initially had strong ties with both after becoming independent. When the PCT withdrew its funding their relationship broke down and only a former Healthy Millborough employee who took on a role in public health occasionally commissions particular projects through NHS funding. The council had continued giving the organisation a small grant, however it was perceived that to some extent they were in competition with each other. Taylor (2012) warns that the Big Society agenda supported by the Coalition government, combined with cuts to local authority budgets, could undermine previously established relationships between the third sector and local government:

> 'The danger is that authorities will either accept a role where they act principally as commissioners, abandoning a more active role in promoting community wellbeing, or retreat into defensiveness, seeing communities – with their new community rights – as critics and competitors.' (Taylor, 2012: 29)

The majority of the organisation's core funding came from BIG Lottery grant; at the time of research, the organisation's only regular local funder was the housing association which gave the initial funding for the food coop and since then had repeatedly commissioned various projects on the estates it manages in Millborough. Janet, a manager who works directly with Healthy Millborough, confirmed that knowing and being able to trust the people involved strongly influenced the decision to give them funding and continue supporting their work. There were strong personal links between the two organisations with Rashid sitting on the housing association's board and David, one of the housing association directors, was a trustee in Healthy Millborough. This relationship was based on a long-standing associations between senior staff in the two organisations:

> '*a lot of staff have been here* [in the housing association] *a long time and a lot of the staff that work at Healthy Millborough are known because most of them came from the council and a lot of staff here came from the council, so that relationship on a one to one level was with people who got a track record that we know about, so whether we bought into the charity at that early stage I'm not sure, but we bought into the individuals who were part of the charity who we knew have delivered in the past so that personal relationship has helped the two companies to build up that relationship'* [David, Trustee]

Healthy Millborough relied on many relationships formed by Rashid and the community development manager when they were employed by the council and their trustees were mostly from a relatively closed network of related organisations:

> '*all my trustees are either directors of statutory bodies, or third sector bodies, or chief officers, or senior managers, a couple of senior elected members as well (…) and they're also key stakeholders and partners in this borough, so we chose them very carefully. A lot of the trustee's organisations have commissioned us in the last three, four years, and they're influential and they've opened up other markets for us so it's quite an interesting relationship really, you know, there are a few conflicts of interest but they're always flagged up.*' [Rashid, Chief officer]

This overlap of roles and responsibilities became very obvious during my fieldwork; when I asked the organisation for contacts of trustees and key external stakeholders that I could interview, all but one on the list I received had both roles (and the exception was the former employee who had a new role in public health). It was therefore difficult to gain a truly

external viewpoint on what it is like to collaborate with the organisation and I can assume that this entanglement and duality of roles may limit Healthy Millborough's board in their strategic thinking about managing the organisation. Furthermore, this group of closely linked organisations is only moderately influential with main public sector funders and key players in the local health system. Gerald, one of the trustees and the chief executive of the local CVS acknowledged that this as a disadvantage for the organisation:

> '*I suspect from what I read about what has happened elsewhere, that there are social enterprises that have done it better than Healthy Millborough because they have GPs on the board, nurses on the board, and that is where we may have undersold ourselves with those relationships, having appropriate people. And definitely elsewhere there are social enterprises running from GP surgeries and the rest of it, they are part of the mainstream, (…) but it's how we could marry that community development approach that Healthy Millborough has with somebody who's got the clout to marry them together, that's what we haven't cracked*.' [Gerald, Trustee]

It is clear that knowing many people locally was very beneficial for the organisation. I would argue however, that they were over-reliant on personal contacts within a relatively small network – possibly because they were limited by the time they could dedicate to networking and the social pool available locally (which is discussed below). The organisation's management seemed to be aware of this and Rashid endeavoured to broaden his network of relationships:

> '*I've become vice-chair of that* [the Connecting Communities subgroup of the Local Strategic Partnership]*, and that's good, because that brings me into contact with more strategic directors and other people, (…) so I try to get into places where I can have some influence, but you've got to work hard on that and that's your networking. And hopefully I can mix in the right circles, and I found out that that's where the deals are made – deals are made in meetings before the meetings. Or the fringe meetings after the meetings, that's where decisions are made.*' [Rashid, Chief officer]

There was a strong view that knowing the right people would help the organisation improve its status locally. Rashid was very determined to raise the organisation's profile, however

admitted to struggling with being diplomatic when building relationships with partners that he 'doesn't like' but feels he has to work with:

> '*sometimes I'm there because I have to get my opinion across, because I simply don't agree with what that person is saying, (…) but the balance is making that point without insulting that person and sometimes you may do that (…) some people do that very well, I still need to, I still need to work on that a bit more.*'
> [Rashid, Chief officer]

This demonstrates the significance of the organisation's cultural and symbolic capital for building social capital: acquiring contacts and gaining access to certain circles is associated with the ability to present a professional image and reputation. It can therefore be stated that Healthy Millborough's social capital may have been limited due to the organisation lacking other resources which are viewed as desirable by potential collaborators.

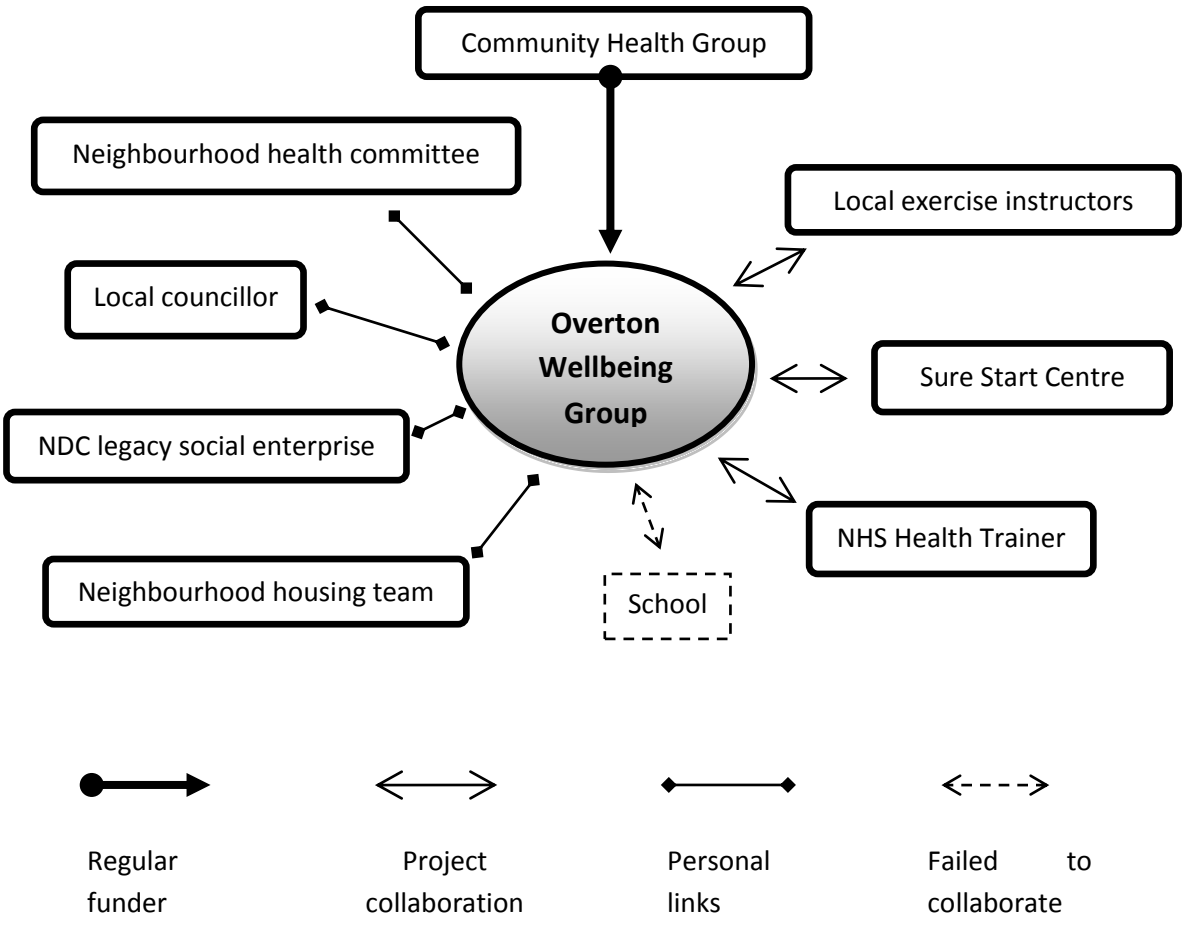


Figure 7: Overton Wellbeing Group's external relationships

Overton Wellbeing Group had a very low public profile in their local area and limited relationships with other organisations. Their activities were mostly financed from a community health group fund established from the New Deal for Communities programme and partially from symbolic payments made by activity participants, raffles etc. They collaborated with local fitness instructors who ran exercise groups and were building up a relationship with the Sure Start centre to run some nutrition activities. Some of the group members were involved in other neighbourhood initiatives and had personal contacts with a local councillor, the local housing team and the NDC legacy social enterprise. Their only relationship with a public sector organisation was with Stacey, a NHS health trainer working in the neighbourhood, who used to be a volunteer in the group. Overton Wellbeing Group worked largely in isolation and their existing relationships, although very positive, were not useful in terms of gaining funding or institutional support for their work.

Overton Wellbeing Group's committee members had been mostly recruited when the NDC projects were started or later by the local authority community worker. They had been involved in the organisation's work for many years, several for about a decade. They recognised that they needed younger volunteers:

> *'It is new members, we need new members, it is continuity as we're, yeah we need new people, younger people. Because to be quite honest with you, Jack's well into his 80's, none of us are great health-wise, none of us know how health will go, so you actually need some younger members to be involved to take over.'* [Mary, Secretary]

However as they had very few external contacts and could do relatively little to promote their work outside their personal circles, they were quite isolated as an organisation. They formed a close-knit and "closed" group and I saw that they greatly enjoyed each other's company. Therefore there was a likelihood that they were perceived as quite self-sufficient and "clique-y"; this posed a risk for the organisation's potential to recruit new volunteers. They were aware of this as a considerable barrier in terms of the organisation's sustainability:

> *'I think it's back to the same old thing, volunteers, people willing to give their time, and dedicate themselves to it, that is one big barrier, that we can't continue if we haven't got volunteers.'* [Pam, Deputy chair]

Several of my respondents commented that there was no enthusiasm for participation on the estate. Lindsey, who had researched participation in a similar neighbourhood, found that lack

of engagement was 'a collective and engrained habit and attitude' (Lindsey, 2013: 10) stemming possibly from lack of skills or confidence, active disengagement, previous negative experiences with organised activities or the complexity of people's chaotic lives. Due to the nature of Overton Wellbeing Group, its activities and social environment, getting new volunteers involved was very challenging, and despite some effort, the group had little success in finding new committee members:

> *'I would warn anybody that would want to do it, it is hard going, it's getting other people on board, it's very hard work.'* [Jill, Chair]

They were particularly disheartened by the fact that two recently recruited volunteers were found to be inappropriate for the role (primarily in terms of how they behaved towards the older service users) and became more of a hindrance than help. Although lay people can very successfully deliver community health promotion activities, this work requires certain personal skills and predispositions, as discussed earlier, a particular habitus. It seemed that the committee members did not have any contacts which they could use to find new volunteers and had not yet found an effective way to promote their work to others locally. With no further support from the local authority the organisation was likely to become unsustainable in the longer term due to an absence of people to run it. Furthermore, not having well established relationships with other local organisations also put its sustainability at risk when they will have to seek other sources of funding. Deficiency of social capital was therefore a major threat to the continuation of Overton Wellbeing Group's work in the future.

The three studied organisations had very different social capital, not only as a result of variation in size and capacity to build support networks, but also because of the different local availability of people with contacts, skills and time. Bridgen (2006) draws attention to the importance of providing disadvantaged communities with "bridging" social capital – creating connections with other social groups and institutions which improve the community's chances of accessing 'health-enhancing resources' and having their voice heard by people in positions of power. Health Connections demonstrated that community health promotion organisations could perform this role through building a network of like-minded organisations and gradually establishing relationships with institutions and individuals. However I assume that this was only possible because they benefited from working in an area of mixed affluence and proximity to a metropolitan centre – this meant that they were able to recruit "high quality" trustees, staff and volunteers with good social and cultural capital, which in turn facilitated building relationships with key stakeholders and understanding the requirements of funding agencies.

The organisation had recruited staff, trustees and volunteers that had appropriate skills and confidence to, for example, target their fundraising efforts directly at members of the general public and local businesses. They have found people locally who have the time and abilities to help run some services:

> *'I suppose because we are so linked into the wealthier end, like you've got [village], we're able to capture a whole load of volunteers, like there are the [village] W.I. which has about 60-70 women that are attending, its amazing, that we go do a presentation and we recruit 5 to 6 volunteers (…), so you've got a social pool. (…) With fundraising we might be able to make most of that aspect feeding in. And again that is also about our sustainability*' [Patricia, Manager]

They had also benefited from highly-skilled and experienced individuals joining the management committee and offering their time to help the organisation develop an effective organisational strategy which could give them more independence from public sector funders.

On the contrary, Millborough is located in an area of post-industrial towns where the social pool is much more limited – there were fewer organisations which would employ professionals and a much less dynamic civil society. It was therefore much more difficult for Healthy Millborough to recruit trustees with a broad range of skills and build a network of supporters who would bring not only professional experience, but also their own valuable social capital. Similarly Overton, although on the edge of a city, forms an isolated community where not many relationships are built with people and organisations from outside the estate. It was also observed that because the area was perceived as undesirable to live in, the working age population was quite transient and it was hard for the organisation to build a stable support network:

> '*I said this to somebody way back when it started (...) you're never going to solve the problem completely because the people who really are, who really get themselves on their feet, don't actually stay in Overton, not all of them anyway, so therefore you get new people moving in.*' [Mary, Secretary]

Even though all three case study organisations delivered services in neighbourhoods with high levels of social need, the socio-economic characteristics of their broader locations undoubtedly influenced the social networks formed by the organisation as a whole and its particular members. Individual predispositions for engagement and the potential for sustained community involvement in organised activities have been found to be strongly dependent on

structural factors affecting individuals and communities:

> 'We found that deeper and more entrenched issues in society are reflected in disparities in the practice of participation. Issues of power and inequality in society are critical to understanding how and why people get involved and stay involved. The uneven distribution of power, social capital and other resources means that not everyone has access to the same opportunities for participation nor do they benefit from the impacts of participation in the same way. Such persistent and structural socio-economic inequalities are clearly challenging to address and cannot be removed without profound political and societal changes' (Brodie et al., 2011: 10)

This highlights the role of "linking social capital" which can be provided by community organisations to support communities in overcoming structural inequalities of power. It is defined as

> 'norms of respect and networks of trusting relationships between people who are interacting across explicit, formal or institutionalized power or authority gradients in society. (…) it pertains to individuals' overall portfolio of social relationships that is demonstrably central to shaping welfare and well-being (especially in poor communities).' (Szreter & Woolcock, 2004: 655)

This form of capital is suggested to enable community members to build working relationships with stakeholders from public service delivery agencies (Szreter & Woolcock, 2004) and to facilitate influencing political health issues (Ferlander, 2007). This is the form of social capital that may ultimately allow organisations to have an improved positioning in the field, and the associated increased chances of being supported in their preferred ways of working. I will argue though, that linking social capital is not easy to acquire for community organisations working in the health field due to the prominence of hierarchies based on professional authority. In the following two sections of the chapter I discuss how the organisations attempted to create and use cultural and symbolic capital to establish relationships with well-positioned individuals or institutions and the challenges associated with this. Both were dependent on the organisations having particular skills and assets which individuals had acquired through education and professional experience, therefore the differences between the three organisations will continue to be evident.

6.3 Cultural capital

Cultural capital, in this thesis, refers to the personal resources held and utilised by the studied organisations, which had been accumulated through socialisation and education and which demonstrate social status. My research identified three aspects of cultural capital which I found to be significant in terms of the studied organisations' sustainability and autonomy: community know-how, promotion skills and business insight and the embodied predispositions of the organisational leaders. The latter, the professional "habitus", was discussed in the previous chapter, therefore this chapter focuses on what Bourdieu (1986) recognised as the "institutionalised" form of cultural capital: education, work-related skills, and experience. The sum of competencies held in the organisations was fundamental to their positioning in the health field.

6.3.1 Community know-how

Working with disadvantaged communities to improve health and wellbeing requires knowledge and skills, however I found in my research that this was largely community know-how which was usually acquired experientially through earlier life experience or "on the job" not through formal training. Within the objectified stock of common knowledge each organisation will have 'a body of transmitted recipe knowledge' which constitutes the 'institutionally appropriate rules of conduct' (Berger & Luckmann, 1966: 83), however it is the personal cultural capital of individuals which allows organisations to successfully work in accordance with their mission. As discussed previously, the organisations sought to recruit staff and volunteers with certain personal predispositions.

The community workers who I observed and spoke to presented a practical, common-sense understanding of health and health-related behaviours. This knowledge, although largely congruent with academic literature on community health promotion, originated in most cases from personal experience of living and working in the community. Many community workers had some professional training, however they acknowledge that academic knowledge constituted only a small proportion of their expertise, as was the case for Kirsty, Healthy Millborough's community dietician:

> *'it's nothing like what I was trained to do and the job I'm doing now. Probably about 2 lectures out of the whole 4 years is what I actually do now, so when you look at it like that now, then really, what was the point then? But I like that I have all that extra knowledge behind it because then I know the reasons why people need to do certain things'* [Kirsty, Community Dietician]

On the other hand, some of the people who worked for the organisations and volunteers did not have any formal qualifications and have learnt the skills they used daily "on the job". Community knowledge gained through sustained and long term engagement was often indicated as key element of the organisations' capital:

> '*You speak to a community worker at Health Connections, they can say – that area, that area, that road that road, those young people – they will know that because they are rooted in the community (...), when I started working at Health Connections I had only been to [town] once in my life and by the end of it I could, you could give me a map and I could go through all the areas and ream off what I know about them because that is core, core knowledge for Health Connections, not just nice to know, but that is a core part of our (hesitation) capital, almost.*' [Kate, Trustee]

As these organisations were relatively small, knowledge could be easily shared amongst people working in the community and also with the organisations' leaders. At the team meetings I attended I witnessed detailed discussions of the issues faced by particular communities and individuals which brought insights from the community to the attention of managers and office-based staff. Furthermore the organisational leaders were experienced community workers and got involved in the community work as much as possible:

> '*because the manager is also seeing the people on the ground as well, they also understand the needs the people (...) so when you're small, you don't have that distance to travel*.' [Patricia, Manager]

Healthy Millborough delivered many of their projects in neighbourhoods with a predominantly South Asian population and having staff members who come from those communities was one of the organisation's key strengths in delivering services there:

> '*we're all from 3 different countries and again, that is a completely different approach we take with each community as well. (...) I suppose we can bring our personal experiences into it and we can understand what makes our community tick as well and that really makes a difference*.' [Chandra, Community health worker]

This pool of knowledge was a valuable form of cultural capital and a significant asset which allowed them to work out solutions that would meet very specific local needs without spending large amounts of money.

Healthy Millborough's Community Gym

Healthy Millborough had done a lot of work with the South Asian community in a neighbourhood which in the 1990's was diagnosed to have some of the worst health outcomes in England. It took over the running of a community gym established by the council, and at the time of research, the gym had about 1200 members who paid a modest yearly membership fee. The organisation's greatest success was creating facilities that were sensitive to the cultural requirements of women, many who had never done any regular exercise before. Andy oversaw this gradual transformation of facilities:

'*So the organisation has shown it can break into areas where there has been very low uptake, the gyms for instance (…) in the early 1990's we* [the council] *decided that we should have some facilities for women, and you know there are particular issues in that area* [South Asian neighbourhood]*, so we decided that 2 afternoons a week – women only, and you get 1 or 2 women coming in, and the gym is at this end of the building and the changing rooms are at this end of the building, and very few women would come. (…) and then we* [Healthy Millborough] *got more money and we moved the women's gym upstairs and we actually put it next to the changing rooms and knocked a hole through, so it's totally self enclosed, you go in there in your outdoor clothes, you do what you have to do in there and come out in your outdoor clothes. (…) just that simple act that was fixed for I don't know, £20k, for 800 women regularly exercising which they weren't doing previously, that's peanuts. (…) and you know, women fight over the treadmills. At 9:15, after school drop-off, there are treadmill wars (…) you know, just a simple act, it's shown that you just have to have the knowledge and understanding of the community, (…) a small amount of money targeted in the right way by the right people can often make a much bigger impact than masses of money which are just indiscriminately thrown out there.*' [Andy, Trustee]

The gym was undoubtedly a local social hub and had expanded its offer to include, amongst others, a spin studio with regular groups, zumba and boxing classes.

'I don't think it attracts the lycra clad fitness fanatics [laugh], which is why I joined our gyms, (…) I wasn't a gym member before, after I started with the charity, we go in practically every day at lunch time, and you know, it's a group of, it's a social thing, we see the same people and we all catch up, and see what we are all doing, and I think the gym is a by-product, you're doing your exercise but I think, you know, it's all ages, all shapes and sizes, and we all enjoy ourselves, and I think that it's just a nice place to go and a nice place to catch up, (…) because people enjoy it and don't even think, well, while I'm enjoying it my

health is actually improving, and health is a by-product of it rather than the other way round.' [Sally, Finance manager]

Once I stood outside the spin studio waiting for a class to finish. When the music stopped and the doors opened about 10 women aged 20-60 years old came out, all visibly tired, but laughing and congratulating each other on their fitness achievements. Interestingly, it was clear that the younger ones were particularly supporting the older ones. I interviewed three women and when I asked if they are longstanding members one replied '*We're part of the furniture here! [laugh]*'.

The attitudes, skills and knowledge which made the organisations' work accessible to people from disadvantaged communities were one of the organisations' key assets and capital resources as they are largely unique to community organisations. This is the form of cultural capital that could make them valuable partners for public sector agencies and funding bodies. However, as Bourdieu and Wacquant (1992) indicate, not every form of capital is equally effective and valuable in every field. "Common-sense knowledge" and "recipe knowledge" related to daily tasks are relatively easily understood by people who share a similar "lifeworld" (Berger & Luckmann, 1966). Doctors and public sector managers (commissioners), through their dominant positioning in the health field, have made the professional healthcare knowledge and skill set the desirable form of cultural capital in the field. Therefore significant social boundaries are drawn: between those who apply appropriate occupational knowledge, theoretical knowledge or role specific knowledge and those for whom it will be unfamiliar and possibly daunting (Berger & Luckmann, 1966). In my interviews I also came across people who greatly valued the organisations' community know-how, however they were not in a position to make any significant changes in the "rules of the game" in the field. Consequently having the cultural resources to work with disadvantaged communities does not in itself guarantee the organisation recognition; I found that turning this form of cultural capital into symbolic capital was not guaranteed and depended on the organisations' environment, but also on their ability to promote their work.

6.3.2 Self-promotion and business acumen

Community know-how allowed the studied health promotion organisations to accurately identify need and find effective ways of meeting it, however their sustainability was dependent on being able to appeal to commissioners and potential business partners. Gaining

influence and support for the organisation's agenda required business competence and persuasive communication; it was this aspect of organisational capital that clearly held back Healthy Millborough and Overton Wellbeing Group. They lacked not only the time to do it, but also expertise and confidence:

> '*So we don't do enough promotion and we need to, we have been asked that maybe we should go to more conferences and speak at more conferences about what we do and put ourselves about a bit, something I need to work on (…). We're looking at different mediums like blogging and other stuff, so hopefully that is going to happen soon.'* [Rashid, Chief officer]

The Healthy Millborough team, despite their enthusiasm to make their work known, did not have anyone who would be overall responsible for a promotion strategy or could focus on communication activities. Overton Wellbeing Group benefited from Jill and Mary's longstanding relationships with other community groups and Jill's husband had volunteered to make some flyers for them to distribute at community events. The group had a Facebook page set up when Sue, the council community support worker was still working with them, but it hadn't been updated since she left her role. The committee members were very enthusiastic about spreading the word about their work, however rarely employed other means than word of mouth or putting up a stall at a local fete to do this.

Health Connections, on the contrary, recognised the importance of not only working in a professional manner, but also ensuring that this is the image presented to external stakeholders. The organisation had been employing a communications officer for several years and had recently made the strategic decision to employ a fundraiser who would focus on diversifying the organisation's income streams. The organisation had a strong focus on marketing and communication with stakeholders and potential partners:

> *'I think we're always going to be different things for different people because that is what we're good at actually, and that is the core of marketing if you like, maybe we are a very marketing-focused organisation and that's because whether it's a service user, a funder, a partner, we are good at being what they want us to be.'* [Kate, Trustee]

A similar strategy of using a double identity was identified in a study of social enterprises which work with homeless people which to remain sustainable would 'blend the legitimacy of third sector organizations with the legitimacy of private firms through balancing the

institutional logics of both.' (Teasdale, 2012: 531). However organisational leaders had to convincingly demonstrate appropriate skills and habitus, as discussed in the previous chapter, to effectively present different sector identities to different stakeholders.

Marketing community health promotion

Marketing and good strategic communication with existing and potential partners was mentioned as a particular strength of Health Connections by all their external stakeholders I spoke to; I was frequently told that they are an organisation that is well known locally and appreciated for their work. The organisation maintained an up-to-date website, Facebook page and Twitter account, as well as providing quarterly newsletters about their work to partner organisations in the community and providing booklets listing all community activities in the area. Kate, who was for a period of time the organisation's communication worker brought with her marketing experience from working in a national charity. She subsequently became a very "hands on" trustee:

'*I recently met with the fundraiser and talked through the fundraising strategy. (...) particularly as we were entering such a challenging time in terms of funding, I felt it was important that they have someone on the board who had marketing, communications and business experience.*' [Kate, Trustee]

She has had a very strong influence on the organisation's promotional work, shaping its marketing and fundraising strategies which had been written down and accepted by the board. There was a strong belief in Health Connections that the value generated by promoting the organisation as a professional and successful one justified the organisational resources dedicated to it:

'I think… [hesitation] *because we are very good at being able to demonstrate that we are delivering and reaching need and we respond to need and that in that sense it is sustainable, there is lots to do with marketing, there are lots of organisations that don't bother (…) and I think if you're not out there, you don't get your reputation, you don't maintain your image, and it's awful that so much effort has to go into it, but it is about communicating what you do (…) it is about constantly looking at what it is that we're presenting, how we present it, making sure we have the things that are actual, it is not just the surface.'* [Patricia, Manager]

My respondents, both inside and outside the organisation, perceived that Health Connections secured themselves a relatively strong position in the local health field thanks to their ability to inform others about their activities, publicise the significance of their work and promote success stories in a professional and engaging manner. This had significantly facilitated obtaining funding and establishing collaborative relationships.

Another crucial aspect of self-promotion is being able to present evidence of the outcomes of their work. Both Health Connections and Healthy Millborough have recognized the importance of this in applying for further funding. Healthy Millborough were focused mostly on organisational metrics collected by Sally, their finance manager:

> '*So we're looking at ways that we're delivering the data and although it's small, it's trying to get that charity level business information out so we can say we've done this many projects, at this many venues, with so many people, and that's probably something we've really strengthened up on this year and we're building on for the next year (...) and we have to have all that information to pull off the shelf and say I'm doing this bid, look what I've done before and back it up with hard data*.' [Sally, Finance manager]

They had also begun to collect more qualitative data from their service users, to find out how they think they had benefitted from the organisation's services, and to be able to capture and feed back to funders the organisation's more intangible outcomes. Health Connections had been particularly praised by James, their NHS commissioner, for their ability to work according to set NHS priorities and requirements and demonstrate associated outcomes:

> '*they do manage to translate the health outcomes straight down to real practice and there is a clear link through the whole thing. So they can take something very abstract, and then they translate them down to this is what happens in practice. And then that is a clear line, it's very unusual to see that. And they can talk to that, well, Patricia can talk to that'* [James, Commissioner]

It was predominantly the role of individuals in leadership positions to establish and maintain relationships with external business partners. The commissioners I spoke to emphasised that understanding current NHS or local authority priorities and the expertise to implement projects that met their requirements was strategically one of the most important areas of competence for community organisations. Organisations had to prove their value in the health system to be given funding. My research also highlighted the significance of the knowledge and skills of the organisations' leaders. Managing a relatively small organisation which merged some of the operational characteristics of a charity, a business and a public sector organisation required a wide range of skills and knowledge:

> '*because it is a small team you end up, your leader is a multi-skilled person that has to do all sorts of stuff you know. The HR department, the finance department, so*

there are, so it's probably not necessarily those skills, but knowing where to get those skills from I think and being a quick learner I suppose, you have lots of steep learning curves, that's what you need when managing a small charity. (…) *so that self-reflection, knowing what you know and knowing what you don't know and knowing where to ask if you don't know*.' [Gerald, Trustee]

Howard and Taylor concluded in their analysis of two "partnership hybrids" that evolved from government programmes that 'it is the skills and experience of particular individuals which make some organisations better equipped to navigate these tensions [of hybridity] and to take advantage of their strategic position at the interface with governmental power' (2010: 194). This is another aspect of organisational hybridity that is problematic for smaller third sector organisations like Overton Wellbeing Group which did not have the necessary skills and expertise. Robinson and Chapman (2013) drew similar conclusions from an in-depth study of third sector organisations in the North East and Cumbria. Organisational governance defined as 'an organisation's ability to hold on to its mission, steer a course, manage its resources and plan realistically and wisely' (Robinson & Chapman, 2013: 32) was found critical to its success in a changing environment and good governance depended on the skills and capital of trustees and managers.

In conclusion, all three studied organisations had the cultural capital needed to successfully engage with the communities they worked with. These skills allowed them to remain relatively autonomous in identifying and responding to the needs of service users and to continue fulfilling their missions. Nevertheless, the observed differences in stakeholder communication and disparities in the three organisational leaders' ability to manage the complexity within their organisations have influenced their access to funding. Possessing the "right" cultural capital gives individuals and organisations social advantage: recognition and the consequent ability to acquire further capital. Knowledge and competence are strongly associated with recognition and esteem in the wider health sector therefore the organisations' external image influences relationships with existing external stakeholders and prospective partners. Cultural capital is the most intangible form of capital, but I would argue it is decisive in the health field. Being able to demonstrate valued forms of cultural capital is necessary to gain symbolic capital; this issue will be discussed further in the next section of the chapter.

6.4 Symbolic capital

Symbolic capital is the value of the forms of capital held by the organisation as perceived by other actors in the field (Bourdieu & Wacquant, 1992). It does not have value in itself, however

Bourdieu ascertains it as fundamental to the use of other forms of capital held by an actor in a field. Symbolic capital was most often referred to by my respondents as "recognition". Two particular forms of symbolic capital emerged as important for the studied organisations: formal recognition such as awards or quality marks and support of healthcare professionals.

6.4.1 Formal recognition

The first form of symbolic capital pursued by the organisations is formal recognition i.e. awards or quality marks. Health Connections had received several health organisation awards, one of which is a national award for health charities. Having an external appraiser commend their work had boosted morale in the organisation, confirming that they had achieved a high standard in their work:

> '*it's a national award, someone's come along, independently and said – wow, you really are doing a really good job, rubber stamp*.' [Pete, Finance manager]

Patricia, the charity's manager, highlighted the symbolic value of receiving an award from an organisation which is well recognised in the health sector:

> '*now because we got that reputation and now because [award giving organisation] is so endorsing of us, I think that really, I mean like, the doctor I've just been to see this morning absolutely rates [award giving organisation] so much, that I hadn't realised how important (…), we've got a massive endorsement, and that again also helps our sustainability'* [Patricia, Manager]

Having increased credibility amongst potential partners in the health sector is viewed as the greatest advantage of winning awards that are given by health bodies. As will be discussed later in the chapter, health professionals are perceived to be sceptical about the effectiveness of community organisations in tackling health issues. Consequently health sector awards which raise the organisations' profile and highlight their achievements were considered a very desirable form of symbolic capital which would hopefully translate into support of local healthcare professionals. Health Connection's external stakeholders had highlighted the significance of their work being positively assessed by independent agencies; they have commented *'they are a recognised charity'* [Joanna, Commissioner] and that *'they have a proven track record'* [Helen, Health Partnership manager].

Healthy Millborough have also received a national award in the period of my study and the staff hoped it would help them improve the organisation's image:

'*we've won an award which was great news, a national award which has brought in some money, some promotion and marketing tools with it and also something that will raise our profile which is very good*.' [Rashid, Chief officer]

I visited their office the day after the manager and another staff member returned from workshops organised for award-winning organisations and they were very motivated to use the skills learned to develop the organisation's promotional strategy and use more social media to gain support for their work. However, with hindsight, it is hard to see any particular outcomes of this and they may be less able to take advantage of this acquired symbolic capital, possibly as a result of limited capacity which was discussed earlier in the chapter.

Healthy Millborough had also decided to apply for the PQASSO quality mark which confirms that charities meet high organisational standards and is a form of recognition of their "professional" status. Sally, Healthy Millborough's finance manager, believed that succeeding in this certification process would strengthen their position when applying for funding:

'*I mean the next big thing that I really want to achieve is a quality mark for the charity, the trustees have agreed and authorised to go for the PQASSO, that is a recognised charity quality mark, and that would mean that funders and even beneficiaries can say that well, that's been externally evaluated the charity (...) PQASSO itself covers every aspect of your organisation, sort of legal, finances, delivery, how you collect your outcomes, the whole basket, which is why we picked it, (...) that opens up doors for more public sector funding, because when you go through tendering they want that reassurance'* [Sally, Finance manager]

It was a common view among my respondents that small, community organisations are often automatically regarded as unprofessional and uncertain partners, particularly by public sector commissioners. It was therefore perceived necessary for them to obtain formal verification of their organisational capabilities to strengthen their symbolic capital.

Overton Wellbeing Group had participated in a national academic public health study which concluded that they, and other similar organisations, provided valuable services, however this had not benefited the organisation in terms of their local status. Because of the organisation's relatively informal status it was difficult for it to attain formal recognition of its work and gain any further benefits from having this type of symbolic capital.

6.4.2 Recognition by healthcare professionals

The second form of symbolic capital that many of my respondents spoke of as crucial to the organisations' positioning in the health field is the recognition and support of their work by healthcare professionals. Community organisations have relatively very little influence over the health field; the priorities and approaches to tackling health problems are established by local NHS bodies and local authorities. It is therefore vital for them to gain recognition for their work in order to influence funding decisions and gain the support needed to continue providing services. The organisations' holistic approach to health promotion, which focuses primarily on wellbeing and addressing the "hidden barriers to health", and their reliance primarily on lay workers are well evidenced approaches, however they carry the risk of mistrust of health professionals and lack of support from statutory bodies (South et al., 2013). Equally their reliance on "common sense knowledge" may be considered as a lack of knowledge and skills by some potential partners. As discussed previously, the organisations' external stakeholders do not necessarily value the forms of capital held by the organisations or have confidence in the community workers' skills:

> 'Professional fields can thus be in competition with non-professional fields, and such conflicts may derive from the fact that what is symbolic capital for one field is simply another form of cultural, social or economic capital for another. ' (Schinkel & Noordegraaf, 2011b: 87)

Mistrust was commonly mentioned by my respondents as a key barrier in establishing collaborative relationships or accessing funding:

> '*And it's about being trusted, again and I think there's a whole issue around health professionals trusting people who are not health professionals to deliver a bit of health*.' [Patricia, Manager]

Health Connections originated as a joint project of the PCT and local council and therefore Patricia and two other members of staff, who have worked in the organisation from its initial stages, were still formally employed by the NHS and seconded to working for an independent organisation. This was considered to give the organisation increased credibility:

> '*I think Health Connections we are in a really, really fortunate position because we, three of us are still employed by the NHS, we're seconded, so we can play the NHS card when we like. (…) They then feel that we're part of them and therefore use our services, because they feel we're legitimate. There is such a closed ring, the NHS is*

so, because they had to do so much training, they feel they are the only ones who can deliver. So that then is a barrier for other organisations to enter.' [Patricia, Manager]

All three organisational leaders perceived this assumption that only health professionals can deliver good services to be a firm mind-set in the health environment:

'I think in some ways everybody knows that I was a nurse, I think they like the fact that you've got some health background, the whole trust thing comes in.' [Jill, Chair]

'for my team it's much harder that they're not professionals in that health world, but for me now (…) they [external stakeholders] *almost assume that I must have it* [a health background] *[laugh], do you know what I mean, you go beyond a level and they do just assume (…) which is rubbish [laugh]!'* [Patricia, Manager]

In the experience of my respondents it was common that healthcare professionals, especially doctors, and commissioners did not perceive the prevention projects offered by community organisations as effective or essential to improving health in disadvantaged communities. The Overton Wellbeing Group volunteers were particularly affected by professional boundaries, feeling very disregarded and undervalued, and finding it impossible to gain access to the health field. This frustration was expressed by Sharon, one of the volunteers:

'*I wouldn't take any gratitude or anything like that, but it would be nice to be recognised what we're trying to do. (...) like the big wigs, like health, you've got the professors and the doctors and you say you're from Overton Wellbeing Group and you're representing health – and who are you? Looking down on us, and I don't think they realise the work we're trying to do to help them, (...) Because they seem to think that because they've got letters behind their name, they're better than us, but in actual fact, we're doing their work for them, so they would just stand back and think about it and actually see what we do, that we're trying to keep people out of surgeries, we're trying to keep people out of hospitals, smoking cessation for one, we do all that, you know, they just don't recognise it.*' [Sharon, Tai-Chi coordinator]

There is almost no recognition by statutory bodies and health professionals locally of Overton Wellbeing Group's work, only the local NHS health trainer collaborates with them on a regular

basis. This lack of support severely limits their influence on local health agendas and restricts the potential reach of their services.

Health Connections and Healthy Millborough had both managed to find support from individual doctors who they found appreciated the importance of including psychosocial interventions in health promotion. Health Connections had established relationships with several GP surgeries whose doctors refer patients to the organisation's services. Julia, the manager of one of these practices, declared their willingness to sustain funding Health Connection's services when they became part of a local Clinical Commissioning Group, although she had doubts whether there would be enough support from the other practices:

> '*I think that if we thought that we are losing some of the facilities that Health Connections provide* [when moving to clinical commissioning groups]*, we as a practice would shout, as long as the other practices get involved as we do, I would expect them all to say – we want to support this service. (...) I would hate to lose Health Connections, they are valuable to us, one voice in 15 wouldn't do it. But if it was half or more, then yes*.' [Julia, GP practice manager]

In Healthy Millborough the engagement with health professionals was more sporadic, however there were cases of successful collaboration. Chandra, who lead a project which aimed to increase rates of cancer screening amongst South Asian women, told me how a senior doctor helped her secure the cooperation of local GPs by endorsing her work and personally familiarising them with the initiative:

> '*The medical director of Millborough Care Trust, doctor M, was very for this project. And he had come on board, and having him to write to the GPs, because me writing a letter, that again, there is no relevance at all. So if I wrote the letter and I got him to send it on my behalf, it meant that, it gave that more importance for them to turn up to these meetings. And doctor M was fantastic throughout this project and he was happy to chair those meeting for me*' [Chandra, Community health worker]

Healthy Millborough made several attempts to engage with local GP surgeries and had found it difficult to establish a good working relationship. Chandra was certain that if doctor M had not been involved, she would have not been able to proceed with her project. It was acknowledged by several of my respondents that the organisation lacked the involvement of health professionals which would facilitate relationships and ensure influence in the local

health system. Gerald, one of Healthy Millborough's trustees, suggested that having a clinician on their board could remedy this:

> '*probably some of that* [lack of] *clinical aspect of the board is a weakness, it's whether it's having a GP or a nurse, or somebody with that professional background that we can, that can help us and guide us. See the mindset of how you pitch to the GPs, but also give the organisation the credibility and the reputation, because just by being there as well, it's as simple as that sometimes*.' [Gerald, Trustee]

Considering the organisations' struggles for recognition in the health field draws attention to the perceived "invalidity" of their expertise. I consider this to be a further symptom of what Green and Tones (2010) describe as the "medicalisation" of social issues and socially engrained perception that it is the "expert" role of medical professionals to advise and support people in adopting healthier lifestyles. But also, as mentioned in an earlier quote by Patricia, the process of socialisation and education determines the categories in which doctors perceive the aims and methods of health improvement. Abbot defines professionalism as 'exclusive occupational groups applying somewhat abstract knowledge to concrete cases' (Abbot, 1988 in: Schinkel & Noordegraaf, 2011b: 85). This is in contradiction to community health promotion where very practical and intuitive knowledge is applied without much theoretical preparation (even though it is often supported by existing theory). The "social stock of knowledge" is unevenly distributed as people are endowed with complex and detailed information for those areas of life which they most commonly encounter. This is pertinent to, for example, occupational knowledge – people have in-depth understanding of their own occupation but know very little about the 'occupational worlds' of others (Berger & Luckmann, 1966: 57-58). Consequently the lines of conflict are often set along structural social divides which designate 'different affinities with the competing theories' (Berger & Luckmann, 1966: 138). There will always be a basis for the competition of rival definitions of reality in society and conflicts will arise between theoretical experts and practitioners. The organisations had a strong sense of mission in terms of "educating" other players in the health field about the benefits of community health promotion, however it was unlikely that they would have enough capacity and authority to bring about significant changes of attitudes. Nevertheless their marginal position in the health field is unlikely to be improved without significant external impetus such as endorsement in national policy or by authoritative health professionals. Even so, judging by the relatively small

scale and short-lived impact of the much talked about (at the time) Marmot Review (Marmot, 2010), I have limited confidence that this would be likely or effective in the near future.

Bourdieu (1986) emphasizes social recognition as the ultimate aim for individuals, and my research has highlighted that this is the case also for community organisations. They need symbolic capital to be trusted by public sector bodies as partners in providing local services and to be given greater freedom to work according to their missions and ethos – thus it is central to both the organisations' sustainability and their autonomy. All three studied organisations started off as public sector projects with large grants and therefore had an established position in the local health system and financial security. Having gained independence their position became volatile and they needed to re-establish their status, however they had varying success in gaining formal verification of the quality and professionalism of their work and a different degree of recognition by other actors in the health field. Relatively high levels of social capital and cultural capital have allowed Health Connections to gain recognition and some influence in the local health field which in turn supported the organisation's sustainability. In contrast, Overton Wellbeing Group has a very low profile amongst professional agencies locally which seem to be both the cause and effect of low symbolic capital. Symbolic capital can therefore be considered the most challenging form of organisational capital to access and equally the most desirable as it is an effective catalyst for organisational resilience.

6.5 Conclusion

In this thesis I have examined how community health promotion organisations' autonomy and sustainability were determined by the opportunities, constraints and "rules of the game" of the fields they worked in and the dispositions of their own organisational habitus. This chapter has further explored the variety of organisational resources which I found to be significant for the organisations' positioning in the health field, which I argue is the key to their autonomy and sustainability. I have established that all of the studied organisations have accumulated and sustained capital resources that are significant to the quality of services they deliver, however they had varied success in securing the forms of capital which were favoured by their stakeholders and which could be advantageous in a market environment. Significant operational capacity and cultural capital, beyond the time and resources needed to deliver services, were found to be necessary for organisations to successfully adapt to the increasingly competitive health field.

Community health promotion organisations need social, cultural and symbolic capital to improve their positioning in the field and to have the "room" to deliver services according to their mission and the specific needs of the communities they serve. I have concluded that these forms of capital are strongly interdependent. Furthermore, developing knowledge and skills, networking, promoting the organisation's work to more powerful stakeholders and securing a good reputation all require staff to commit time. Consequently, a shortage of time and operational capacity may prevent organisations from taking advantage of opportunities or addressing identified threats to their autonomy and sustainability.

In this chapter I have also demonstrated how the diversity in capital assets held by community health promotion organisations has resulted in a variation in their positioning in the health field. Several authors (McLaughlin, 2004; Alcock, 2010; Buckingham, 2011) have suggested that the third sector is undergoing a process of bifurcation – McLaughlin refers to two subsectors:

> 'one 'modernized' sector dependent upon substantial public money and dedicated to the production of 'world class' public services and one non-institutionalized sector dependent upon primarily voluntary income and working at the margins of public service delivery and in the sphere of civil society' (2004: 560)

I have concluded that even in the specialised area of community health promotion organisational trajectories are likely to become increasingly divergent in a period of considerable turmoil in the health field. Organisations which are better socially resourced will be able to improve their positioning in the field and are likely to hybridise, whilst those which have limited capacity will be increasingly marginalised or become unsustainable. Community organisations working in the most disadvantaged neighbourhoods in England are expected to independently overcome the challenges associated with an unfavourable institutional environment, deficient policies and structural inequalities (Milbourne, 2013) – all of which were noted in this study. In these circumstances community health promotion organisations which have not accumulated sufficient social resources are highly likely to lose their capacity to act within the health field, and consequently forgo their autonomy and sustainability.

Chapter 7

Research conclusions and implications

> *Social agents are not "particles" that are mechanically pushed and pulled by external forces. They are rather bearers of capitals, and depending on their trajectory and on the position they occupy in the field by virtue of their endowment (volume and structure) in capital, they have a propensity to orient themselves actively either towards the preservation of the distribution of capital or toward the subversion of this distribution*. (Bourdieu & Wacquant, 1992: 108-109)

This ethnographic research study provided the opportunity for extensive engagement with community health promotion organisations and gaining insight into how they are managing in a period of change and uncertainty. With health inequalities continually widening (Buck & Frosini, 2012) and increasing pressures on the NHS there is a visible need for long-term preventative work with the most disadvantaged communities. Community-centred initiatives which support people in making healthier lifestyle choices through improving confidence and social relationships can be an effective approach to prevention (Green & Tones, 2010) and third sector organisations are well placed to be intermediaries between the state and communities (Marmot, 2010). However challenges associated with circumstances of austerity and marketisation have led some to struggle financially and limit the scope of their activities, with some closing down. Similarly, with increased pressure on third sector organisations to deliver according to government targets and the dominance of whole population and individualised approaches as preferred health improvement measures, some organisations are struggling to maintain autonomy of purpose and action (Independence Panel, 2011). The aim of this research was to gain understanding of how community health promotion organisations were being affected by these changes and what were the factors that were significant to organisations maintaining autonomy and sustainability. I consider the findings of this thesis to be both timely and valuable – they provide an in-depth account of how community health promotion organisations sought to continue delivering services in a turbulent period. This thesis therefore contributes new knowledge about the barriers they face in sustaining their work and the support mechanisms and resources that can facilitate overcoming them.

Despite common warnings of mission-drift occurring in third sector organisations involved in public service delivery, the community development ethos and a strong sense of mission were largely uncompromised in the studied organisations, preserved by the beliefs and

predispositions of their leaders and community workers. However I concluded that the extent to which organisations were able to work according to their missions, values and preferences was dependent on the strength of their positioning in the health field. Likewise, their positioning was a key determinant of sustainability – the organisation's ability to secure the resources needed to deliver services. However their positioning in the field and their potential to influence it were dependent on a complex range of factors. They were both characteristics of the field such as an accommodating institutional environment and supportive key players, as well as the organisation's ability to accumulate and deploy organisational capital resources which are valued in the field. I established that class, professional and institutional relations are highly significant in local health fields therefore the capital held by community health promotion organisations, and also individually by their leaders, is a strong determinant of their positioning. Consequently, differences between the three organisations' ability to remain sustainable and autonomous reflected primarily the variation in their local institutional context and in their access to a pool of people with adequate social and cultural capital. This suggests that structural and contextual factors play a deciding role in determining how well organisations are able to manage in challenging circumstances.

The research findings also allow for a critical evaluation of hybridisation as a strategy employed by community organisations to better meet external expectations and achieve greater resilience. Considering the case study organisations, in the best case scenario hybridisation was embraced, but was still not fully effective in securing sustainability and autonomy whilst generating significant tensions within the organisation. In the worst case, hybridisation was not even considered as a viable option and the organisation's sustainability and capacity to act were limited by its institutional isolation. Therefore I found the expectation that community organisations will achieve autonomy and sustainability by taking on ways of working which are managerially-driven and entrepreneurial to be misguided.

This chapter brings together the key findings of the research and their implications. Firstly, the significant methodological aspects of the research are examined. Then I discuss the theoretical contribution of this thesis. This is followed by recommendations for practitioners working in community health promotion. Finally, I set out the policy implications of this research which raise broader questions about the role of the state in supporting citizen wellbeing and about how public sector organisations manage relationships with community organisations. The thesis is concluded with a discussion of the limitations of the study and of the directions for future research.

7.1 Methodological findings

This study was carried out as an ethnography using a multiple-case study design to allow for an in-depth understanding of the variety of factors and relationships that influence organisational sustainability and autonomy. Considering my limited initial knowledge of how these organisations work and what were the challenges they faced, the ethnographic approach has proven to be successful in exploring the organisations' ways of working, their relationships in the local health fields and how these influence their work. Ethnographies typically entail long-term engagement at a single organisation. In this study, because the organisations were small and my aim was to gain insights which were relevant to similar organisations working in different geographical and institutional context across England, I opted for shorter research periods at multiple sites. Studying three organisations that have different resources and work in different contexts meant that through comparing and contrasting their experiences and what they were able to achieve important similarities and differences were identified. Spreading the "rolling revisits" at Health Connections and Healthy Millborough over the course of a year (between first visit and presentation of initial findings to staff and trustees) was also valuable as it allowed for including a temporal perspective – observing changes within the organisations and in their environment. Overall, a multiple-case study ethnography proved to generate rich data that also had considerable breadth.

"Creative workshops" were a methodological innovation implemented during my last data-gathering visit at Health Connections and Healthy Millborough. Their aim was to give the community health workers a chance to jointly engage in an activity that would help explore the organisations' identity and role in the local health system in an indirect way. In both cases this proved to be useful in corroborating findings generated through individual interviews and observation. However in Health Connections it went even further. When the five community health workers were left to create their collage (with a recorder in the centre of the table), I found that they devoted only some of their attention to the task of making the collage. Their conversation first turned to discussing current projects and the logistics of organising an event at their community allotment. Then they started reflecting on their shared experience of working together at the organisation but feeling relatively disconnected from each other due to busy schedules and work pressures. It was obvious that the 30 minutes they had to complete the task of making a collage was for them a unique opportunity to spend "unstructured" time together to connect and to openly discuss their concerns about what was happening in the organisation and how each of them could make adjustments to allow for more time to talk to colleagues. This activity therefore revealed in quite a lot of depth how the

community workers were experiencing the tensions associated with the organisation striving to do "more for less" to meet the expectations of funders. I had become aware of this, to some extent, through interviews and observation, but had not grasped the strength of feeling nor its universality amongst the community workers. Therefore I found that "creative workshops", as a method that allowed participants to freely discuss issues that matter to them, gave staff members a valuable opportunity to "reconnect" with each other and at the same time significantly enriched my research data.

7.2 Having "room" in the field: key determinants of sustainability and autonomy

This thesis contributes several new insights into community organisations' capability to respond to unfavourable political and economic conditions in a way that would improve their positioning in the health field and give them more "room". The findings of this research demonstrated that community health promotion organisations develop their response to turbulent political and financial conditions in accordance with their normative preferences and predispositions, but face constraints in terms of skills and capacity. Robinson and Chapman suggest that instability and uncertainty are "normal" for third sector organisations and some organisations deal with it better than others (2013: 14). This study similarly found that organisations were, on one hand, predisposed to flexibility and dealing with change, on the other, did not "automatically" adjust their practices to their field as suggested in Bourdieu's theorisation of habitus. They had a "reflexive habitus" (Sweetman, 2003) so were inclined to adapt, but this was carefully considered; they resisted changes that were directly conflicted with their values and "way of life". However I found that they also did not necessarily have sufficient capacity to make changes to their ways of working and to sustain them. The differences between cases in this thesis demonstrated that the ability to strategically respond to threats to organisational sustainability and decreasing autonomy is related to the volume and quality of organisational capital.

Secondly, the findings indicate that the organisations' ability to maintain autonomy and sustainability are determined by individual agency and structural constraints which is illustrated by the dynamic relationship between individual predispositions (habitus), organisational resources (capital) and organisational context (field). The study evidenced that the structure of local health fields is a fundamental barrier to community health promotion organisations achieving autonomy and sustainability. Relations within local health fields are shaped by class, professional status and institutional frameworks, thus upholding the value of the forms of capital held by the "incumbents" and preventing community organisations from improving their positioning. Consequently their efforts to find adequate resources to fulfil their

missions were inhibited by structural power relationships. Interestingly, I found a pattern of local "path dependence" which suggests that in areas where there is a long history of successful relationships between public bodies and voluntary organisations, other agencies are more aware of their benefits and receptive to their needs.

Thirdly, this research demonstrated that having appropriate social connections (social capital), the time and skills to promote the organisation's work (cultural capital) and support of health professionals (symbolic capital) may lead to an improved position and some influence in the health field. Skills and competencies relating to external communication and self-promotion gain organisations much needed recognition and the potential to influence the "rules of the game". In this study I identified three routes through which community health promotion organisations can gain more "room" as providers of public services in the local health field. The first is building relationships and partnerships with other like-minded local organisations which can form strategic coalitions to influence local policy agendas. The second is gaining the support of key players in the health field such as commissioners or health professionals. The third is gaining formal recognition through external quality marks or awards – although these only have as much reach as the organisation can access through its external communication. Nevertheless these options are not equally available to all organisations. The size of the organisations' support network and the socio-economic characteristics of their broader locations determine the availability of people with the appropriate connections, skills and time. There is therefore a risk that organisations will become unsustainable or that they will have less independence of voice and action as a result of insufficient organisational capacity and capital.

The reviewed literature suggested that third sector organisations that deliver public services may have to make a trade off between sustainability and autonomy. My findings contrasted this and indicated that for community health promotion organisations autonomy and sustainability are strongly interrelated because they were both associated with the organisations' position in the local health field, and consequently, the amount of "room" they had. Therefore, where organisations can deploy their operational, social, cultural and symbolic capital resources to gain a stronger position in the health field, they are better able to protect their values and preferred ways of working whilst remaining sustainable.

7.3 Organisational hybridity as an aspiration – or not

This research considered the suitability of a hybrid organisational model for community health promotion organisations which work to improve health in disadvantaged neighbourhoods. In

political rhetoric it is often portrayed as a panacea for third sector organisations suffering from government austerity and the marketisation of public services, promising greater independence from the state and financial resilience based on the diversification of income sources. It is encouraged both explicitly through political declarations and implicitly through policy decisions on a national and local level. Challenging circumstances are rendering it a necessary strategy for the third sector, however this thesis demonstrates that hybridisation is not a straightforward route to autonomy and sustainability.

The case study examples demonstrate that attitudes to organisational hybridity can be very different in community organisations, despite facing similar circumstances of withdrawal of support from public agencies and an increasingly competitive funding environment. Overton Wellbeing Group decided to manage running their groups on minimum budgets maintaining independence from external funders. For Healthy Millborough moving further into the hybrid realm was undertaken with some reluctance, but it was treated as critical to sustainability. From the perspective of time the organisation recognized that they were not entirely successful at achieving this. At Health Connections well-managed hybridity became perceived as a necessity, but also as a way of fulfilling their organisational potential and their mission of responding to local need.

This thesis explores the notion of a “hybrid habitus” contributing a cultural perspective to the theoretical understanding of hybridisation in the third sector. It refers to organisations reconciling conflicting ideas and ways of working and highlights that adapting to bureaucratic requirements or becoming more entrepreneurial requires not only capacity, competencies and skills, but also the right deep-seated predispositions which cannot be “learned”. The research findings demonstrated that hybridisation required pre-existing capacity and appropriate forms of cultural capital as well as personal predispositions of organisational leaders. It bears the risk of generating strong tensions within organisational culture which may lead to distortions of organisational identity and undermine autonomy. These are not insurmountable, however I observed the changes to ways of working have an unsettling effect on the people that work there. I found that Cultural Theory’s categories of “grid” and “group” which describe two dimensions of culture are a useful tool for understanding the congruence and tensions between the ways of working typical of the public, private and third sector. This theoretical finding resonated very strongly with the case study organisations when I presented it as a tentative theory during my final visits. This model of hybridity allowed them to understand the

changes they were going through and anticipate where the possibly irresolvable conflicts of principles may occur.

Hybridisation looks like an effective strategy in “playing the game” in local health fields, however I found that it is not in itself sufficient for improving the organisations’ autonomy and sustainability. Even when aspects of an organisation’s work are changed to meet external expectations, they had still lacked the support and recognition for their community development approach. On the other hand, rejecting hybridisation puts organisations at risk of being marginalised and consequently unable to fulfil their mission due to being outside of the field. I found organisations need to be willing to “play the game”, but also need capital resources to have a strong position in the field. In this way autonomy and sustainability are interrelated: they are aided by hybridisation, but without capital resources and an environment in which community organisations have “room”, it will not have the desired effect. This study has evidenced that overall, organisational hybridity is not a desirable or a feasible model to pursue for community health promotion organisations.

7.4 Community organisations and the role of the state: challenging the status quo

The NHS will face enormous financial pressures from patients with long-term conditions in coming years and health inequalities between the well off and disadvantaged in society prevail. Disadvantaged communities suffer from a range of “wicked” problems, yet their members are known to be unreceptive to state interventions, and often lack the social resources to overcome their position of social exclusion. The current approach seems to be for the state to withdraw its support and abandon its sense of responsibility, leaving much to the mechanisms of the market and the efforts of “civil society”. However in the long term this seems entirely counterproductive. Comments from prominent health organisations including the British Medical Association (Porter, 2015), Royal Collage of Nursing (Royal Collage of Nursing, 2015), Faculty of Public Health (Barr & Taylor-Robinson, 2015) and the King’s Fund (Buck, 2015a) are warning of the serious consequences of cutting local public health budgets and neglecting prevention referring to it as ‘the falsest of false economies’ (Buck, 2015a). Community health promotion organisations provide upstream interventions which address the root causes of poor health and deteriorating wellbeing; implementing individualised interventions and population-wide programmes will not on its own address the psychosocial issues which often underlie poor health. Nevertheless community development is 'peripheral within the broad responsibilities of mainstream public sector organisations' (Gilchrist & Taylor, 2011: 74) and the empirical evidence presented in this thesis confirms that relationships

between community health promotion organisations and public sector organisations are, at best, tenuous. I found that even where there are individual commissioners or professionals who see the value of community-based health promotion, very little can be done to support it due to overarching political agendas and increased pressure on welfare spending. Renewed appreciation is needed of the value of community-centred health promotion and community health promotion organisations should be supported as significant contributors to the local health system. Therefore I have formulated several policy recommendations based on the findings of this research which aim to challenge the status quo to provide an environment where community health promotion organisations can remain sustainable whilst having autonomy in fulfilling their missions.

Firstly, politicians and policymakers need to accept their responsibility for citizens' wellbeing, which is not only dependent on physical health, but primarily on social and psychological factors. South et al. (2013) note that that there is little recognition that the state has an active role to play in encouraging greater citizen and community involvement in public health initiatives. They make a strong argument for organisational support from within the health system as well as state financial backing for community-led initiatives if they are to be sustainable and effective. The state delivers care through the NHS however there remains 'a relative deficit of sensitive linking social capital' (Szreter & Woolcock, 2004: 662). Organisations that foster social participation and build community networks provide a social resource that individuals can draw on, and these are critical to improving the wellbeing of those affected by social exclusion:

> 'The social capital perspective also informs us that if we normatively approve of the goal of enhancing population health, we cannot achieve this through material inputs alone, or simply through 'technological fixes', whether 'imposed' or magnanimously 'granted' by those with superior resources. (…) In the public services and in developed societies in general it is in fact these precious resources of human relationships, effort, and care (…) that are crucial, rather than material inputs, alone.' (Szreter & Woolcock, 2004: 663)

Involving community organisations in public service delivery therefore needs to be perceived as an important route to supporting and developing communities through engagement and empowerment, not as an optional extra or a cost-cutting measure.

Secondly, recognition is needed that community health promotion organisations cannot deliver services in disadvantaged communities independently of state financial backing. It is well documented that local organisations are not evenly distributed amongst communities and that disadvantaged areas have significantly more third sector organisations that get the majority of their funds from state sources than neighbourhoods that are better off (Clifford, 2012; Lindsey, 2013). It is important to challenge the dominating narrative that organisational sustainability depends primarily on their "resilience" and chosen strategies (Milbourne, 2013). Policy rhetoric places responsibility for success/failure to remain sustainable solely on organisations and their ability/inability to adapt appropriate resilience strategies. Instead more needs to be done to consider the influence of the state and market on the conditions set for their survival.

Furthermore, I have found that the expectation of policymakers that community organisations can successfully compete in a marketised environment for public service contracts is unrealistic; it requires organisations to have significant capacity and managerial and administrative skill sets which go beyond what they need to deliver services (and receiving funding for these "core costs" is very difficult). Hybridising or implementing a social enterprise model is argued to be inappropriate for some organisations due to the nature of their work and their social context:

> 'This is because there are some activities that operate outside of the market, making it highly improbable if not impossible that they can be traded. (...) These are undeniably good things that contribute to the rich tapestry of society, enriching lives and communities, but it is hard to see how they can be run on a social enterprise model. And while many activities can be run solely on voluntary effort, there are still moments when equipment needs to be bought, or specialist expertise employed.' (Cox & Schmuecker, 2013: 11)

This, as I have confirmed through my research, is true for organisations that are small and entirely volunteer-run and those that are larger and more professionalised – they have limited means of sustaining their work other than through public funds. Also funding for community services is often driven by requirements for "value for money" and measurable outcomes which disregard the time and effort required to foster relationships in the communities. They also neglect less tangible outcomes related to the "hidden barriers to health" which the organisations are aiming to address. Maintaining the status quo, where there is a shrinking pool of resources available to community organisations and progressing marketisation, puts

smaller organisations with less social and cultural capital at a disadvantage and risk of closure due to inability of meeting bureaucratic requirements:

> 'The policy narrative about organisations moving towards trading and contracts or being run entirely on voluntary effort seems to neglect this point [that grants often bring added value above and beyond the activity that they directly pay for]. This is a view that appears to filter down into some parts of the sector itself. (...) many aspire to social enterprise, which is welcome. But it also seems to indicate some organisations trying to fit into a narrative that is not, in reality, suited to them.' (Cox & Schmuecker, 2013: 12)

It should not be expected that all community organisations can adapt to these requirements and adopt ways of working that are essentially in conflict with their beliefs and dispositions; those which are able to engage with communities most closely through their local remit and "non-professionalised" image struggle to meet the formal requirements of public sector contracts. Buckingham's (2011) research demonstrated that there is significant diversity within the third sector and large, professionalised organisations which could meet contracting requirements had different remits and strengths in terms of service delivery than the smaller ones which struggled to gain public funding through contracts. The findings of my research support her argument that policymakers need to be more aware of this diversity and significance of organisational size and "ways of life" for the outcomes of their work. When establishing the policy objectives that are to be met by the involvement of third sector organisations in service delivery it is important to understand whether organisations who are able to match the purposes assigned to them are equally able to meet commissioning requirements. As discussed above, hybridisation is not a viable option for all organisations and therefore some are unable to remain sustainable in such an environment, or they dedicate a disproportionate amount of organisational time and effort to applying for funding. It is therefore necessary to change the "rules of the game" and establish contracting mechanisms that would take into account the community organisations' limited capacity and value their local knowledge.

Finally, the research makes a case for increasing awareness and recognition amongst commissioners and health professionals of the benefits associated with applying the positive model of health and a community development approach to health promotion. Community organisations work differently to statutory organisations and this difference in approach should be seen as their strength and make them valuable partners, not treated as challengers.

I have found that organisations need recognition just as much as they need financial resources to maintain their autonomy and be in a position to advocate for their service users, with this symbolic capital providing a significant boost to their positioning in the health field. Community organisations need to be respected by statutory bodies and health professionals to be able to fulfil their bridging and social support role in the health system. The Public Health White Paper (Department of Health, 2010) endorses third sector organisations and declares government support for partnership working across sectors, however without any specific policy measures following on from this and increasing budgetary pressure, there is little incentive for changes to established ways of working at a local level.

Community health promotion organisations work with the most vulnerable groups in their communities and their services bring added value through facilitating lay involvement and community organising – they play a unique role in the local health system. However their sustainability and autonomy of purpose, voice and action fundamentally depend on the active support of public sector bodies, third sector infrastructure organisations and health professionals and it is the role of policymakers to create a favourable policy and institutional environment for community health promotion work. Without this community health promotion will continue as a contested way of working and organisations will be unable to fulfil their potential as drivers of health improvement in disadvantaged communities. In the worst case scenario, this holistic way of working with communities towards improved health and wellbeing may be lost as a result of organisations similar to the ones studied not having sufficient “room” in the health field to remain sustainable.

7.5 Limitations of study and further research

This study has contributed new knowledge about how the organisations’ work is affected by changes in their local institutional environment, the key factors that influence their autonomy and sustainability and about hybridisation as a possible route for greater resilience. However inevitably, this study has its limitations. These are twofold – the constraints of the case study method which provides limited scope for generalising the findings of this study and the breadth of themes and aspects of organisational work covered which possibly limited the depth of analysis.

The study methodology limits the applicability of the findings to other settings as many findings, particularly ones referring to organisational practices, are context specific. There was strong resemblance between all three studied organisations in terms of the theoretical explanation therefore it seems that the applied theoretical approach could be successfully

used elsewhere. Further research could however be carried out to test the significance of the relational characteristic on a wider scale. The scope of interest in the study which covered individuals, organisations and their fields meant that I identified many common themes across the three case study organisations and these were drawn out, discussed and linked together in the analysis chapters. The breadth of issues inevitably meant compromising on the depth of analysis of particular topics; therefore there is room for further studies which could take the analysis further. Of particular interest would be further examination of the relationship between sustainability and autonomy in community organisations – my findings suggest that there is a positive relationship as both benefit from a strong organisational positioning in the field, however it is commonly argued that there is a trade-off between them. Furthermore, gaining deeper understanding of the "hybrid habitus" through a more focused study of how organisations "make sense" of hybridisation and negotiate the inherent cultural tensions would be of value.

Apart from compensating for the described limitations, I have identified several other interesting directions for further study:

- Verifying the "path dependency" hypothesis of local public sector-third sector relationships – does institutional history really matter?
- Taking stock of service user views – does it make a difference to service users what kind of organisation delivers health promotion services, whether public, private or third sector (or hybrid)?
- Examining the significance and role of the different forms of organisational capital in other public service fields such as education, social housing or advocacy – how easy is it for small third sector organisations to have "room" in the field?

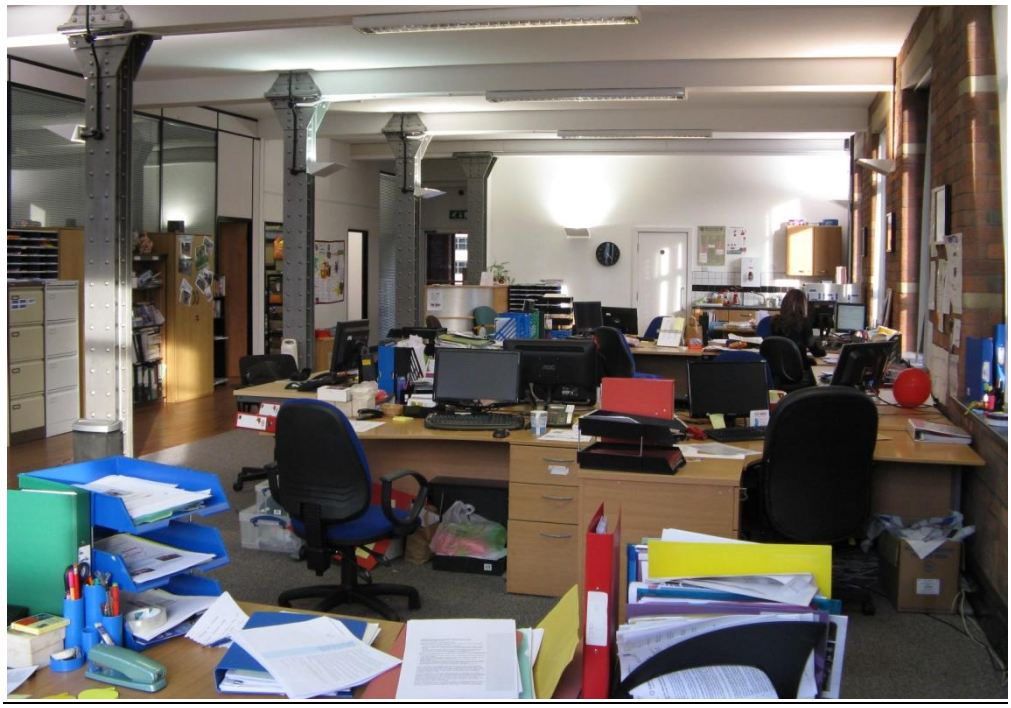
Appendix A: Person profiles

Name	Role	Organisation
Alice	Community development manager	Healthy Milborough
Andy	Community assets manager /Trustee	Local Authority/ Healthy Millborough
Chandra	Community health worker	Healthy Milborough
Clare	Community nutrition worker	Health Connections
David	Director/Trustee	Housing Association/Healthy Milborough
Emily	Community health worker	Health Connections
Emma	VCS liaison officer	City Council for Overton
Gerald	Director /Trustee	CVS/ Healthy Milborough
Helen	Health partnership manager	CVS local to Health Connections
James	Third sector commissioner	PCT local to Health Connections
Janet	Community projects manager	Housing Association local to Healthy Millborough
Jill	Chair	Overton Wellbeing Group
Joan	Trustee	Health Connections
Joanna	Commissioner of services for the elderly	Local Authority for Health Connections
Julia	Practice manager	GP surgery local to Health Connections
Kate	Trustee – marketing specialist	Health Connections
Kirsty	Dietician/Gym instructor	Healthy Milborough
Mandy	Communications officer	Health Connections
Mary	Secretary	Overton Wellbeing Group
Mike	Manager	Community Centre local to Health Connections
Nicky	Community health worker	Health Connections
Omar	Community health worker	Healthy Milborough
Pam	Deputy chair	Overton Wellbeing Group
Patricia	Manager	Health Connections
Pauline	Community leader/service user	Healthy Millborough
Pete	Finance manager	Health Connections
Rahim	Asylum seeker project worker	Health Connections
Rashid	Chief officer	Healthy Milborough
Ricardo	Manager	Youth Charity local to Health Connetions
Salima	Networker coordinator	Health Connections
Sally	Finance manager	Healthy Milborough
Sharina	Administrator	Health Connections
Sharon	Tai-Chi coordinator	Overton Wellbeing Group
Stacey	Health trainer	PCT local to Overton
Steve	Trustee	Health Connections
Sue	Community development worker	City Council for Overton

Appendix B: Fieldwork photographs

Health Connections

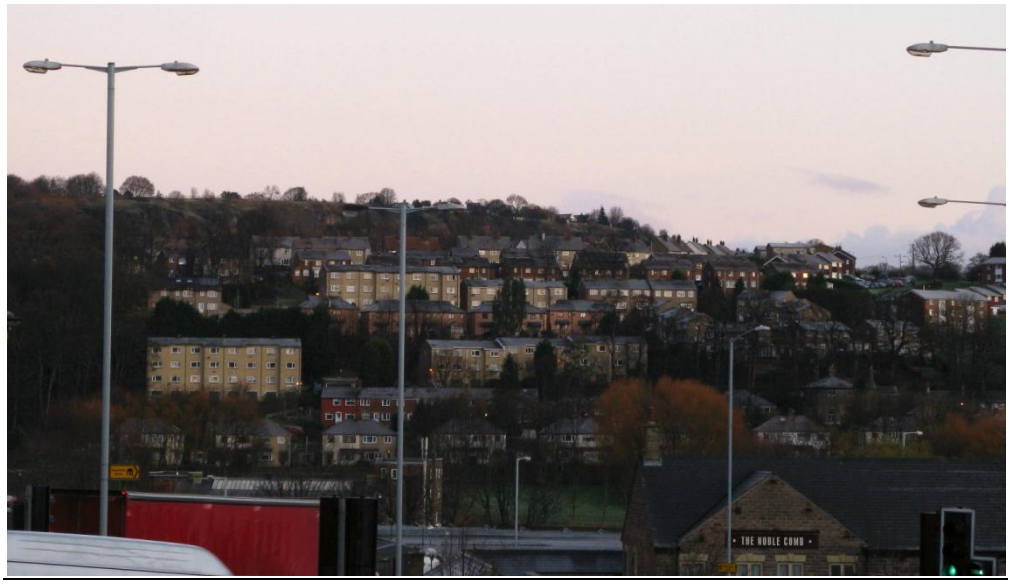
1) View from behind manager's desk



2) Town centre

3) Leaving the town centre

4) Hillside estate



5) The derelict and industrial meets prosperous and trendy

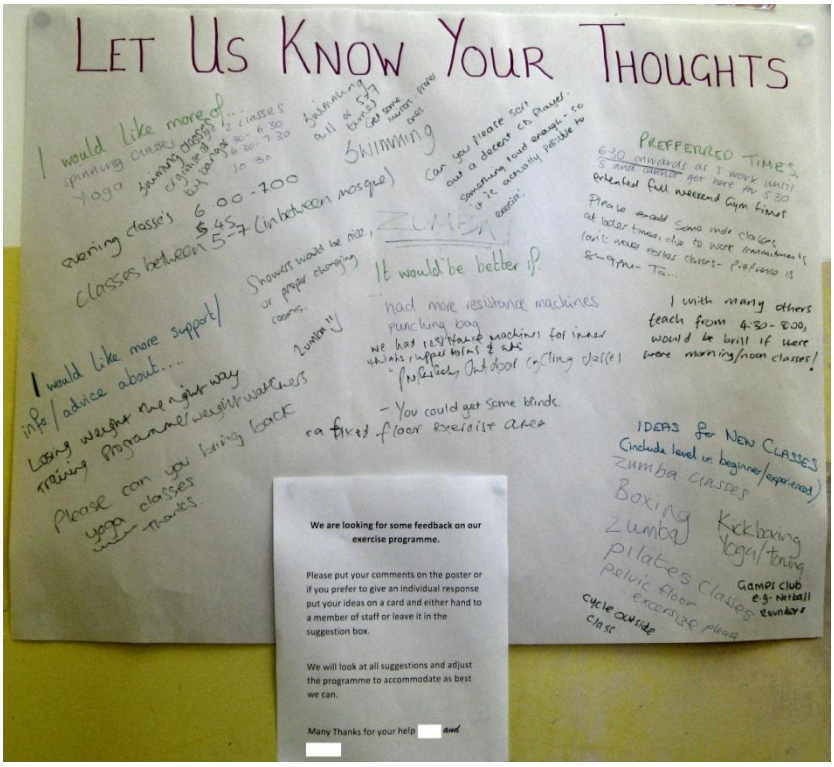
Healthy Millborough

6) Town centre – council office block

7) Estate on the periphery of Millborough

8) 2 mosques amongst the terraces

9) Community gym feedback poster



Overton Wellbeing Group

10) New community hub

11) Estate tower blocks

Appendix C: Information sheets

UNIVERSITY OF Southampton
School of Social Sciences

TSRC Informing civil society

Promoting Health: The Community Approach

INFORMATION FOR MANAGERS

Background

This project is being carried out as part of a PhD study by Magda Zasada, who has broad experience in conducting research involving charities and public sector organisations as well as previous experience of working in a healthcare organisation. It is being funded by the University of Southampton and supported by the Third Sector Research Centre, hosted jointly by the Universities of Southampton and Birmingham. It is supervised by Prof John Mohan and Dr Pauline Leonard in the School of Social Sciences, University of Southampton.

Aims

Amid increasing expectations that the "Big Society" could provide an antidote to persisting health inequalities, this study aims to describe and gain a good understanding of how local organisations work to improve health in their communities by asking:

- What are their aims?
- What kinds of services do they provide?
- How do they approach the challenges they face?
- How is their work perceived by local organisations and individuals?

Method

The project involves case studies of 3 organisations. It is based on qualitative data and in each case will involve:

- Analysis of documents: e.g. mission statement, contracts, reports.
- Interviews with staff, service users and other interested parties.
- Observation of the organisation's public activities.

Outcomes

The results of the study will be disseminated through publication in journals and presentation at conferences among a broad group of academics and practitioners interested and involved in policy, public health and the third sector. It is hoped that the research will provide a novel contribution to policy planning and will stimulate debate and innovative thinking around

effective community health promotion. Furthermore it is seen as a valuable opportunity to present examples of successful and original approaches to health promotion to a wider audience. Research findings will also be fed back to the participating organisations, including information on how the organisation and its work are perceived by external stakeholders, service users and other representatives of the local community.

Governance

Best practice and safeguarding of research participants throughout the research process will be ensured through the following measures:

- Approval of the School of Social Sciences Research Ethics Committee.
- Sponsorship and insurance provided by the University of Southampton's Research Governance Office.
- Criminal Records Bureau check for researcher.
- No sensitive data collection.
- Confidentiality and anonymity for all participants.
- Informed consent and the option of withdrawal at any time for all participants.

In case of complaint please contact:
Dr Martina Prude
Head of Research Governance
University of Southampton
Tel. 023 8059 5058

Thank you for your interest in this research.

Promoting Health: The Community Approach

PARTICIPANT INFORMATION SHEET

About the research

This project is being carried out as part of a PhD study by Magda Zasada. It is being funded by the University of Southampton and supported by the Third Sector Research Centre. It is supervised by Prof John Mohan and Dr Pauline Leonard in the School of Social Sciences, University of Southampton.

This study aims to describe and gain a good understanding of how community organisations work to improve health in their communities by asking:

- What are their aims?
- What kinds of services do they provide?
- How do they approach the challenges they face?
- How is their work perceived by local organisations and individuals?

What the research will involve

The project involves case studies of 3 organisations and in each case will involve:

- Analysis of the organisation's documents: e.g. mission statement, contracts, reports.
- Interviews with the staff, service users and other interested parties.
- Observation of the organisation's public activities.

The ethics of this research

The project has obtained the approval of the School of Social Sciences Research Ethics Committee and the researcher has a valid Criminal Records Bureau check. All data will be treated confidentially and no sensitive data will be collected. All project participants will remain anonymous and have the right to withdraw from the project at any time.

In case of complaint please contact:

Dr Martina Prude
Head of Research Governance
University of Southampton
Tel. 023 8059 5058
Thank you for your interest in this research.

Appendix D: Consent forms

UNIVERSITY OF Southampton
School of Social Sciences

TSRC
Informing civil society

Promoting Health: The Community Approach

Consent form for organisations

Please insert your initials in the boxes if you agree with the corresponding statements.

We have read the project information sheet and understand what participation in this project involves for the organisation. ☐

Whilst we are participant in this project :

We agree to work with the researcher to facilitate necessary data gathering e.g. access to documentation. ☐

We will assist in identifying external collaborators to participate in in-depth interviews. ☐

We will assist in approaching our service users who would be appropriate respondents for interviews. ☐

We will enable the researcher to carry out participant observation of our public work and the office work of the organisation (not involving sensitive or confidential information). ☐

We will enable the researcher to carry out in-depth interviews with staff/volunteers working with the organisation. ☐

We understand that we will remain anonymous in all research output. ☐

We know that data from this project will be stored securely on password protected computers. ☐

The right to withdraw

We know that we are free to withdraw from the project at any time. ☐

Signed _____ Date_____

Print name _____

On behalf of the organisation _____

Countersigned _____ (researcher) Date _____

Promoting Health: The Community Approach

Consent form for participant observation

Please insert your initials in the boxes if you agree with the corresponding statements.

I have read the project information sheet and understand what participation in this project involves. ☐

Participating in this project

I agree for the researcher to participate in this activity and make written notes regarding what they have observed. ☐

I understand that my personal details will be treated confidentially and I will remain anonymous in all research output. ☐

I understand that no direct reference will be made to particular individuals or observed events in the research output. ☐

I know that data from this project will be stored securely on password protected computers. ☐

The right to withdraw

I know that I or any other activity participants are free to ask the researcher to leave at any time. ☐

Activity name and date _____

Signed _____ Date_____

Print name _____

Countersigned _____ (researcher) Date _____

Promoting Health: The Community Approach

Consent form for individuals

Please insert your initials in the boxes if you agree with the corresponding statements.

I have read the project information sheet and understand what participation in this interview involves. ☐

Participating in this project

I agree that the interview may be audio recorded. ☐

I understand that my personal details will be treated confidentially and I will remain anonymous in all research output. ☐

I know that data from this project will be stored securely on password protected computers. ☐

The right to withdraw

I know that I am free to withdraw from the interview at any time. ☐

Signed _____ Date_____

Print name _____

Countersigned _____ (researcher) Date _____

Promoting Health: The Community Approach

Consent form for staff workshop

Please insert your initials in the boxes if you agree with the corresponding statements.

I have read the project information sheet and understand what participation in this workshop involves. ☐

Participating in this project

I agree that the workshop may be audio recorded. ☐

I understand that my personal details will be treated confidentially and I will remain anonymous in all research output. ☐

I know that data from this project will be stored securely on password protected computers. ☐

I agree for the researcher to retain the pieces created in this workshop for purposes of analysis. ☐

The right to withdraw

I know that I am free to withdraw from the workshop at any time. ☐

Signed _____ Date_____

Print name _____

Countersigned _____ (researcher) Date _____

Appendix E: Interview guides

External Stakeholders

INTRODUCTION:

- Information on the research, about recording and use of data, duration of interview, signing of consent form.
- Introduction of the respondent, their role in the community and their connections with the studied organization.

PART 1: RELATIONSHIP WITH ORGANISATION

- How and when did you first come across X?
- Have you (or your organisation) been directly involved in working with X?
  - **If no, go to part 2**
- Why did you (your organisation) decide to collaborate with X?
  - Strategic reasons
  - Effectiveness/methods of service delivery
  - Community benefits
- What were your expectations of working with X?
  - Outcomes
  - Methods
- What does your current collaboration entail?
- Would you say that your collaboration with X has changed in any significant way over the period of time you have described?

PART 2: THE COMMUNITY

- Can you tell me a bit about the community X works with?
- Would you say there is anything specific about the region and the local area that makes it distinctive in its health and community needs?
- Who would you say X's work is mainly targeted at (social groups, neighbourhoods)?
- Would you say X fills a particular gap in service provision in the local area?
  - If yes, what is it?
- Do you think individuals and communities could do more to look after their own health?
  - If yes – what?
- What barriers to leading healthier lifestyles do you think they face?
- Do you think organisations like X can help people overcome them? How?

PART 3: ORGANISATION'S ROLE AND IMPACT

Based on your knowledge and experience…

- How would you describe X's role in the community?
- What would you say are the main challenges X faces in its work in the community?
  - How are they addressed?
- How would you describe X's approach to tackling health issues in the area?
  - ❖ Understanding of how health/wellbeing can be improved
  - ❖ The community/environment role in individual wellbeing?
  - ❖ The individuals' role in managing own health
- Would you say that X's work is innovative?
  - If yes, in what way?
- Would you say X has an area of particular expertise?
  - ❖ Methods of engaging with hard to reach groups
  - ❖ Partnership working
  - ❖ Community involvement
- Is there anything else you would like to see X doing?
- How would you describe the effects of X's work?
  - ❖ Positive
  - ❖ Negative
- Do you think you have some effect beyond what other organisations working locally could achieve?
  - ❖ Improved individual wellbeing and health outcomes
  - ❖ Behavioural changes
  - ❖ Social value (e.g. community empowerment, engagement, formal and informal support networks)
- What would you say contributes to the organisation's accomplishments?
  - ❖ Internal factors
  - ❖ External factors
- Are there any barriers which prevent X from achieving their full potential?
  - ❖ Internal factors
  - ❖ External factors

Managers

INTRODUCTION:

- Information on the research, about recording and use of data, duration of interview, signing of consent form.
- Introduction of the respondent, their background, other professional/voluntary role experience.

PART 1: PERSONAL EXPERIENCE OF WORKING IN THE ORGANISATION

- How long have you been working in X and how long in your current role?
- What did you do before?
- How did you first get involved with X?
- What brought you to your role in X? Is there anything that particularly attracted you to it?
  - Principles and values
  - Aims and goals
  - Particular way of working
  - Connection with existing member of staff
- What did you expect this job to be like?
  - Were these expectations met?
- What do you personally want to achieve through your role?
  - In the organisation
  - In the wider community
- Why do you see this as important?
  - How do you work towards achieving this?
  - How challenging is it?
- What "gets you up in the mornings"?
- What is the best thing about working in X?
  - Most satisfying aspects of work
  - Most motivating aspects of work
- Is there anything in particular that you would like to change in the organisation (but potentially is not presently achievable)?
- Would you say that things have changed in X over the period of time you have been here?
  - If yes, how?

PART 2: THE ORGANISATION'S ROLE IN THE COMMUNITY

- What would you say are the organisation's main aims?
- How are its priorities established?
  - Is there any formal process of assessing local needs?
  - Who is involved in this?
- Who would you say X's work is mainly targeted at (social groups, neighbourhoods)?
  - Why do you think they are in need of X's support?

- Would you say these are relatively "stable" populations or are there many people moving in and out?

- Would you say there is anything specific about the region and the local area that makes it distinctive in its health and community needs?
- How would you describe X's approach to tackling health issues in the area?
  - ❖ Understanding of how health/wellbeing can be improved
  - ❖ The community/environment role in individual wellbeing?
  - ❖ The individuals' role in managing own health
- How is this approach worked out?
- Would you say there are any specific principles the organisation bases its work on?
  - ➢ If yes, what are they?
- What would you say are the main challenges X faces in its work in the community?
  - How are they addressed?

PART 3: ACTIVITIES AND IMPACT

- Where do ideas for the services you provide come from?
- Who is involved in designing them?
- How would you say X's work fits in with what other local agencies and organisations do?
- Would you say X fills a particular gap in service provision in the local area?
  - ➢ If yes, what is it?
    - ❖ Service coproduction
    - ❖ Partnership working
    - ❖ Methods of engaging with hard to reach groups
- Why would you say there is a need to provide different services than the existing statutory ones?
- Would you say that X's work is innovative?
  - ➢ If yes, in what way?
- Do you think that this model of working and services could be successfully implemented anywhere in the country or is it quite specific to the area?
- Are there any recommendations you would make based on your experience to others involved in similar organisations?
- How would you describe the effects of X's work?
  - ❖ Positive
  - ❖ Negative
- Do you think you have some effect beyond what other organisations working locally could achieve?
  - ❖ Improved individual wellbeing and health outcomes
  - ❖ Behavioural changes
  - ❖ Social value (e.g. community empowerment, engagement, formal and informal support networks)
  - ❖ Would you say third sector/community organisations can do this kind of work better?
- Is there anything you would perceive to be the organisation's most important achievement?
- What would you say contributes to the organisation's success?
  - ❖ Internal factors

- ❖ External factors (regional, local?)
- Are there any barriers which would prevent X from achieving its full potential?
  - ❖ Internal factors
  - ❖ External factors (regional, local?)
- If you had 15 minutes to speak to the Prime Minister today, what would you tell him about X's work? What policy recommendations would you make based on your experiences?

PART 4: COLLABORATION AND COMMUNITY RELATIONSHIPS

- How do you want X to be perceived by the community/commissioners/partners?
  - ➢ To what extent do you think you have succeeded in achieving this?
- Would you say there are any external factors which significantly affect X's work?
  - ❖ Availability of funding
  - ❖ Requirements of commissioning bodies
  - ❖ Relationships with other organisations
  - ❖ Availability of community resources and capacity
  - ❖ "Competitors"
- If you could influence the work of other agencies in the area (NHS, LA, other collaborators), what would you recommend to them?
- Who does the organisation collaborate with in its work?
  - ❖ Formal collaboration
  - ❖ Informal collaboration
    - ➢ What benefits does this bring?
- Where would you say lies the value of working in partnership with others?
- Are service users/community members involved in any way in service design?
  - ➢ If yes, how?

PART 5: LEADERSHIP AND VISION

- How would you describe the team you are building in X?
  - o What personal characteristics do you look for when recruiting?
  - o What does the induction process for newly-recruited staff look like?
  - o Would you say that tend to "fit in" quite easily or does it take time for them to adjust to their roles?
  - o How are staff encouraged to develop in their roles?
- What is the role of volunteers in X?
  - o How do they come to be involved in the organisation – are they actively recruited, or do they approach you?
  - o How would you say they contribute to its work?
  - o Do you think the volunteers benefit from their work with X?
- What is the role of the trustees? What do they get involved in?
- How are strategic decisions made and the organisation's future direction established?
  - o Who is involved in the process?

- Who would you say makes most of the decisions regarding day-to-day matters in the organisation?
  - Are there any specific areas of responsibility?
    - ❖ Budget
    - ❖ Contents of activities
    - ❖ Collaboration formal/informal
    - ❖ External communication
    - ❖ Internal communication
- Why was X turned into a charity and a registered company?
  - What are the benefits?
  - What are the drawbacks?
- Would you consider your organisation to be a social enterprise?
  - ❖ Why/why not?
- How sustainable would you say X is in the long run?

Service Users

INTRODUCTION:

- Information on the research, about recording and use of data, duration of interview, signing of consent form.
- Introduction of the respondent, where they live, what activities thy like doing, what links them with the studied organization.

PART 1: SERVICE USE

- How did you find out about X and its activities?
- What was your first experience with X?
- How long ago was this?
- Why did you decide participate?
- What did you think it (the activity) would be like?
    - Were your expectations met?
- What activities have you participated/what services have you used since?
    - How often? Regularly?
- How do you find more/new information about activities?
- Do you participate in activities / use similar services provided by any other organisation?

PART 2: SERVICES PROVIDED BY THE ORGANISATION

- How would you describe your experiences with X so far?
    - Anything particularly good about them?
    - Anything bad/negative?
- Would you change anything in the service you are using?
- Would there be anything else you would like X to provide?
- Do you think you would find similar services in the area if X wasn't here?

- relationship with X's staff
- meeting other people
- information provided

PART 3: ORGANISATION'S ROLE IN THE COMMUNITY

- How do you think people in your community can be encouraged to keep themselves healthy and well?
    - Education/Awareness
    - Improved individual skills

- ❖ Access to facilities
- ❖ Change mentalities, overcome cultural issues

- Is there something that community members can do themselves to improve their health and wellbeing?
- Are there any barriers to people having more healthy lifestyles?
  - ➢ What are they?
- What do you think the role of organisation's like X should be?
- Who do you think may benefit most from X's services?
- Do you think there is something particular that helps X make a difference in the community and to individuals?
  - ❖ Internal factors
  - ❖ External factors
- Do you think X comes across any barriers in its work?
  - ❖ Internal factors
  - ❖ External factors

Staff members

INTRODUCTION:

- Information on the research, about recording and use of data, duration of interview, signing of consent form.
- Introduction of the respondent, their current job role in the studied organisation.

PART 1: PERSONAL EXPERIENCE OF WORKING FOR THE ORGANISATION

- How long have you been working in X?
- What is your professional background, what did you do before?
- How did you first come across X?
- What brought you to work in X? Is there anything that particularly attracted you to it?
  - Principles and values
  - Aims and goals
  - Particular way of working
  - Connection with existing member of staff
- What were your expectations of what your day-to-day work would entail?
  - Were they met?
  - When you first started working, did you feel you "fit-in" or did it take some time for you to learn your role and how to work within X?
- What would you say is the purpose of your role?
  - In the organisation
  - In the wider community
- What do you personally want to achieve through your role?
  - Why do you see this as important?
  - How do you work towards achieving this?
  - How challenging is it?
- What "gets you up in the mornings"?
- What is the best thing about working in X?
  - Most satisfying aspects of work
  - Most motivating aspects of work
- Is there any one thing that you would change that would make working here better?
- What opportunities are there to feed ideas or concerns upwards?
- Would you say that you are involved in decisions that affect your work?
  - If yes, how and to what extent?
- How are you supported in your role?
- Do you feel you are encouraged to develop yourself in your role?
  - How does this come about?
- Is teamwork common in X, do you rely a lot on others in your work?
- Would you say that things have changed in X over the period of time you have been here?
  - If yes, how?

PART 2: THE ORGANISATION'S ROLE IN THE COMMUNITY

- What would you say are the organisation's main aims?
- Who would you say X's work is mainly targeted at (social groups, neighbourhoods)?
    - Why do you think they are in need of X's support?
    - Would you say these are relatively "stable" populations or are there many people moving in and out?
- Would you say there is anything in particular about this area that makes it more difficult to improve the population's health?
- What would you say are the main challenges X faces in its work in the community?
    - How are they addressed?
- Do you know how priorities are established?
    - ➢ If yes, could you tell me more about it?
    - Is there any formal process of assessing local needs?
    - Who is involved in this?
- How would you describe X's approach to tackling health issues in the area?
    - ❖ Understanding of how health/wellbeing can be improved
    - ❖ The community/environment role in individual wellbeing?
    - ❖ The individuals' role in managing own health
- How would you say this approach is worked out?
- Would you say there are any specific principles the organisation is bases its work on?
    - ➢ If yes, what are they?
- Would you say there is a sense of purpose and direction regarding where the organisation is heading in the future?
    - ➢ If yes, where/who is it coming from?

PART 3: ACTIVITIES AND IMPACT

- Could you tell me a bit about the services X provides?
    - Where do ideas for these services come from?
    - Who is involved in designing them?
- How would you say X's work fits in with what other local agencies and organisations do?
- Would you say X fills a particular gap in service provision in the local area?
    - ➢ If yes, what is it?
    - ❖ Service coproduction
    - ❖ Partnership working
    - ❖ Methods of engaging with hard to reach groups
- Why would you say there is a need to provide different services than the existing statutory ones?
- Do you think this model of working and service provision could be successfully applied anywhere in the country?
- Would you say that X's work is innovative?
    - ➢ If yes, in what way?
- How would you describe the effects of X's work?

    - ❖ Positive
    - ❖ Negative
- Do you think you have some effect beyond what other organisations working locally could achieve?
    - ❖ Improved individual wellbeing and health outcomes
    - ❖ Behavioural changes
    - ❖ Social value (e.g. community empowerment, engagement, formal and informal support networks)
- Is there anything you would perceive to be the organisation's most important achievement?
- What would you say contributes to the organisation's accomplishments?
- What would you say hinders its work?
    - ❖ Internal factors
    - ❖ External factors

PART 4: COLLABORATION AND COMMUNITY RELATIONSHIPS

- Would you say there are any external factors which significantly affect X's work?
    - ❖ Availability of funding
    - ❖ Requirements of commissioning bodies
    - ❖ Relationships with other organisations
    - ❖ Availability of community resources and capacity
    - ❖ "Competitors"
- Who does the organisation collaborate with in its work?
    - ❖ Formal collaboration
    - ❖ Informal collaboration
    - ➢ What benefits does this bring?
- Are service users/community members involved in any way in service design?
    - ➢ If yes, how?

Trustees

INTRODUCTION:

- Information on the research, about recording and use of data, duration of interview, signing of consent form.
- Introduction of the respondent, their background, other professional/voluntary role experience.

PART 1: EXPERIENCE WITH ORGANISATION

- How long have you been involved with the organisation?
- Did you have any previous experiences of being a trustee?
- Are you involved in any other ways in this organisation or others?
- How did you first come across X?
- Why did you decide to become a trustee in X? Is there anything that particularly attracted you to it?
- What were you expectations relating to the role?
  - Were they met?
- What is the best thing about working with X?
  - Most satisfying aspects of work
  - Most motivating aspects of work
- What would you say is the worst thing?
- Is there anything in particular that you would like to change in the organisation (but potentially is not presently achievable)?
- Would you say that things have changed in X over the period of time you have been with X?
  - If yes, how?

PART 2: THE ORGANISATION'S ROLE IN THE COMMUNITY

- What would you say are the organisation's main aims?
- Who would you say X's work is mainly targeted at (social groups, neighbourhoods)?
  - Why do you think they are in need of X's support?
- Would you say there is anything specific about the region and the local area that makes it distinctive in its health and community needs?
- What would you say are the main challenges X faces in its work in the community?
  - How are they addressed?
- How are its priorities established?
  - Is there any formal process of assessing local needs?
  - Who is involved in this?
- How would you describe X's approach to tackling health issues in the area?
  - Understanding of how health/wellbeing can be improved
  - The community/environment role in individual wellbeing?

- ❖ The individuals' role in managing own health
- Would you say there are any specific principles the organisation bases its work on?
  - ➢ If yes, what are they?

PART 3: ACTIVITIES AND IMPACT

- How would you say X's work fits in with what other local agencies and organisations do?
- Would you say X fills a particular gap in service provision in the local area?
  - ➢ If yes, what is it?
    - ❖ Service coproduction
    - ❖ Partnership working
    - ❖ Methods of engaging with hard to reach groups
- Why would you say there is a need to provide different services than the existing statutory ones?
- Would you say third sector/community organisations can do this kind of work better?
- Would you say that X's work is innovative?
  - ➢ If yes, in what way?
- Do you think that this model of working and services could be successfully implemented anywhere in the country or is it quite specific to the area?
- Are there any recommendations you would make based on your experience to others involved in similar organisations?
- How would you describe the effects of X's work?
  - ❖ Positive
  - ❖ Negative
- Do you think you have some effect beyond what other organisations working locally could achieve?
  - ❖ Improved individual wellbeing and health outcomes
  - ❖ Behavioural changes
  - ❖ Social value (e.g. community empowerment, engagement, formal and informal support networks)
- Is there anything you would perceive to be the organisation's most important achievement?
- What would you say contributes to the organisation's success?
  - ❖ Internal factors
  - ❖ External factors
- Are there any barriers which prevent X from achieving their full potential?
  - ❖ Internal factors
  - ❖ External factors
- If you had 15 minutes to speak to the Prime Minister today, what would you tell him about X's work? What policy recommendations would you make based on your experiences?

PART 4: COLLABORATION AND COMMUNITY RELATIONSHIPS

- How do you want X to be perceived by the community/commissioners/partners?

- To what extent do you think you have succeeded in achieving this?
- Would you say there are any external factors which significantly affect X's work?
  - Availability of funding
  - Requirements of commissioning bodies
  - Relationships with other organisations
  - Availability of community resources and capacity
  - "Competitors"
- Who does the organisation collaborate with in its work?
  - Formal collaboration
  - Informal collaboration
  - What benefits does this bring?
- Where would you say lies the value of working in partnership with others?

PART 5: LEADERSHIP AND VISION

- What would you say is specifically the role of the trustees? What do they get involved in?
- How would you describe the team the organisation is aiming to build?
  - What is expected of the organisation's leaders?
  - What is expected of the organisation's staff?
- How are strategic decisions made and the organisation's future direction established?
  - Who is involved in the process?
- Why was X turned into a charity and a registered company?
  - What are the benefits?
  - What are the drawbacks?
- Would you consider your organisation to be a social enterprise?
  - Why/why not?
- How sustainable would you say X is in the long run?

Appendix F: Staff workshop plan

Workshop aims:

- To creatively engage staff members in a fun, but meaningful collaborative activity.
- To encourage reflection on their work and the organisation's role in the community.
- To stimulate discussion about key values, beliefs and assumptions underlying the organisation's work.

INTRODUCTION (10 minutes)

- Information on the research project and aims of workshop, about recording and use of data, signing of consent forms.

ACTIVITY: QUALITY POSTER (50 minutes)

This is planned as a "facilitated form of talking" – the collaborative, creative process is meant to encourage participants to crystallise their thoughts, negotiate ideas and think of the bigger picture.

Task: Make a poster that presents important aspects of the organisation itself and its relationship with its local context (communities, organisations etc). You can be as realistic or as abstract (symbolic) as you like. You can work as a group or make individual elements and then bring them together. You have 30 minutes to discuss and create.

Materials available: flipchart paper, paper, pens, magazines, post-its, scissors, glue

PRESENTATION OF POSTER AND DISCUSSION:

Please tell me about your poster.

- Why have you chosen to portray these particular characteristics?
- What does it say about: [aspects to probe if appropriate]
  - Aims and aspirations
  - Values and beliefs
  - Priorities
  - Understanding of what is health, what contributes to individual/community wellbeing
  - Relationships with service users
  - Influence of external stakeholders

Appendix G: List of codes

1) Autonomy
    a) In identifying needs and aims
    b) In service design and delivery
    c) Having a voice and influence
2) Sustainability
    a) State of resources
    b) Funding sources
    c) Enablers
    d) Barriers
3) Organisational context
    a) Distribution of public funding
    b) Setting priorities
    c) Stakes and vested interests
    d) Competition and conflict
    e) Power
    f) Collaboration
    g) Institutional environment
    h) Existing social capital
    i) Change and reform
4) Organisational culture
    a) Values and beliefs
        i) Defining health
        ii) Aims of health promotion
        iii) Relationships with service users and communities
    b) Being professional

c) Entrepreneurial spirit

d) Predispositions of leaders

e) Identity management

f) Sector self-identification

g) Internal relationships

h) Tensions

5) Organisational capital

a) Time and operational capacity

b) External relationships

i) Funders

ii) Positive relationships

iii) Difficulties with relationships

c) Knowledge and skills

i) Community know-how

ii) Marketing and communication

d) Recognition

i) Awards and quality marks

ii) By health professionals

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