The Role of the Voluntary Sector in Cross-Sector Collaborations: An NHS Multispecialty Community Provider

Thesis

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The Role of the Voluntary Sector in Cross-Sector Collaborations: An NHS Multispecialty Community Provider

Daniel Haslam

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Thesis submitted for the degree of Doctor of Philosophy (PhD)
Centre for Voluntary Sector Leadership
Faculty of Business and Law
The Open University
March 2020
Abstract

This thesis explores the role of the voluntary sector in the delivery of an NHS Multispecialty Community Provider (MCP) pilot project in the area of Erewash, England. It draws on engaged research, informed by ethnographic and action research traditions through which a broad range of data were gathered in order to present a detailed picture of the project in practice. In doing so it contributes both to the academic literature and to the work of practitioners and policy makers.

Firstly, it identifies the tensions inherent in the voluntary sector’s role as ‘transmission belt’ organisations, providing empirical evidence of this role in practice and building on Albareda’s (2018) original conception. In addition, it suggests the pressure to work in this way risks damaging the sector’s relationship with both service users and communities. Secondly, the thesis explores the ways that trust, power, and control interact in collaborative contexts, utilising Bachman’s (2001) notion of different ‘traditions’ to suggest that the voluntary and public sectors reflect different ways of working that are interactions of ‘personal’ and ‘system’ trust and power. These different traditions surface tensions that make collaboration difficult. Thirdly, the thesis identifies the complex leadership dynamics at play in collaborative contexts and the dominance of NHS hierarchical aspects, particularly in relation to clinical professionalism. Despite this, the thesis builds on Huxham and Vangen’s (2000a) notion of ‘making things happen’ to identify the positive and proactive leadership role the voluntary sector can enact in practice. However, it cautions that, as both directive and facilitative forms of leadership are needed in collaborative contexts, an increased focus on public sector-initiated collaborations could paradoxically make the sector less collaborative.

The thesis offers suggestions for both policy and practice, as well as identifying potential ways to take the research forward in the future.
Acknowledgements and Dedication

Many people have helped me during this PhD journey. I would firstly like to thank my fellow students, both within the Faculty of Business and Law and in others at The Open University. Two in particular – Eduardo Frias and Emily Breese – have given me a great deal of support. Cristina, Richmond, Michela, Lindsey, Jo, Lindsay and Ronald, have all helped me at different times and in different ways, as have many others.

I’m very grateful for the advice and guidance of my supervisors: Professor Siv Vangen, Dr James Rees, and Dr Carol Jacklin-Jarvis. I would not have been able to complete this work without them. I have also benefitted from a significant amount of support from other staff at the university, including Tracey Moore, Lin Nilsen, and Claire Caron. I’d also like to thank the staff in the Graduate School and the Open University Student Association for providing me with a variety of opportunities to contribute to university life. Thanks also to everyone at the The Open University Library.

I was very fortunate that the establishment of The Centre for Voluntary Sector Leadership (CVSL) at the university allowed me to pursue my research in a focussed environment with like-minded colleagues and I’m grateful to everyone involved in it. I would like to thank Mr Anthony Nutt specifically for providing the funding for both CVSL and for my PhD studentship. Without that opportunity this thesis would not exist.

My thanks also goes to the participants of my research, in particular the staff at Erewash Voluntary Action for displaying the same welcoming approach to me as they do to all of their service users.

Finally, I would like to thank Elizabeth who has been a large part of my life before, during, and hopefully for many years after this journey. Her support has been the most important and the most appreciated. I dedicate this thesis to her.
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**Table 1-1 Key Terms and Abbreviations**

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<th>Definition</th>
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<tr>
<td>SYFV</td>
<td>The NHS Five Year Forward View (SYFV) document (NHS, 2014) – this set out much of the planning that led to the creation of Wellbeing Erewash.</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Group – the local commissioning bodies of the NHS formed following the 2012 Health and Social Care Act.</td>
</tr>
<tr>
<td>Collaboration</td>
<td>“any situation in which people are working across organisational boundaries towards some positive end” (Huxham and Vangen, 2005, p.4)</td>
</tr>
<tr>
<td>Community</td>
<td>The notion of community in the Wellbeing Erewash project primarily refers to the geographic area of Erewash.</td>
</tr>
<tr>
<td>Control</td>
<td>Control in this thesis refers to the direct ability to make decisions about aspects of voluntary-public sector working. It is what Bachman (2001) suggests is about the coordination between organisations. In this sense control is a ‘function’ shared by trust and power (Ran and Qi, 2018).</td>
</tr>
<tr>
<td>ECCG</td>
<td>Erewash CCG – the local Clinical Commissioning Group in Erewash that was responsible for bidding for the Wellbeing Erewash vanguard project</td>
</tr>
<tr>
<td>Erewash</td>
<td>The area in which the Wellbeing Erewash took place. It is a non-metropolitan district and borough in eastern Derbyshire, England.</td>
</tr>
<tr>
<td>EVA</td>
<td>Erewash Voluntary Action – the local voluntary sector infrastructure organisation and ‘named lead’ for the voluntary sector within the Wellbeing Erewash project. EVA was the base for this research.</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner(s) – the frontline of primary care services and also a key voice within Clinical Commissioning Groups.</td>
</tr>
<tr>
<td>LA</td>
<td>The Local Authority</td>
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</tr>
<tr>
<td>Leadership</td>
<td>Making things happen in practice.</td>
</tr>
<tr>
<td>Making things happen</td>
<td>Huxham and Vangen's (2000a) notion of leadership within collaborative contexts, focussing on what actually happens in practice.</td>
</tr>
<tr>
<td>MCP</td>
<td>Multispecialty Community Provider – a type of NCM (New Care Model) – of which Wellbeing Erewash was one.</td>
</tr>
<tr>
<td>NCM</td>
<td>New Care Models – new models of care introduced in the NHS ‘Five Year Forward View’. Wellbeing Erewash was one of these NCMs</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health Service - the NHS is a complex organisational entity. As such referring to ‘the NHS’ can imply several different aspects. Broadly, use of ‘NHS’ within this thesis will refer to the NHS as a whole. Specific aspects within this will be referred to separately.</td>
</tr>
<tr>
<td>Power</td>
<td>In collaborative contexts power is a mechanism, entangled with trust (Ran and Qi, 2018), that acts upon the function of control “based on the selection of a negative hypothetical possibility regarding alter ego’s (re-)actions” (Bachman, 2001, p.350). Traditions of power exist at both the personal and system level.</td>
</tr>
<tr>
<td>QfH</td>
<td>Quality for Health – a Quality mark developed specifically to demonstrate the quality of the voluntary sector in relation to work with the NHS. QfH was introduced in Erewash alongside WE and delivered by EVA.</td>
</tr>
<tr>
<td>Role</td>
<td>The position and purpose that the voluntary sector had in the Wellbeing Erewash project – see Section 6.2.</td>
</tr>
<tr>
<td>STP</td>
<td>Sustainability and Transformation Plan (later ‘Partnership’) – an attempt to join up NHS services with local authority health and social care.</td>
</tr>
<tr>
<td>Transmission Belt</td>
<td>Albareda’s (2018) conception that contrasts the role of the voluntary sector organisations as both ‘boosting diverse participation’ and ‘producing a consistent message’ within the sector. Applied in this thesis the demands are reframed as acting as a ‘route in’ to communities and a ‘voice for’ them.</td>
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<tr>
<td>Trust</td>
<td>In its broadest sense trust is a means of coping with uncertainty and “works on the basis of positive assumptions about alter ego’s willingness and ability to co-operate” (Bachmann, 2001, p.350). It is the ‘entangled twin’ (Ran and Qi, 2018) of power. Like power, traditions of trust exist at the personal and system level.</td>
</tr>
<tr>
<td>Vanguard</td>
<td>See WE – below</td>
</tr>
<tr>
<td>VS (Voluntary Sector)</td>
<td>The voluntary sector is &quot;a space of organisational activity located between the state, market and private familial spheres comprising a diversity of organisational types including charities, social enterprises, faith, community and grassroots groups.&quot; (Rees and Mullins, 2016b, p. 3). Unless specified, use of ‘the voluntary sector’ within this thesis refers to the general sector as in this definition.</td>
</tr>
<tr>
<td>WE</td>
<td>Wellbeing Erewash – the project studied for this research. WE was a pilot New Care Model (NCM), also referred to as a ‘Vanguard’.</td>
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Chapter 1. Introduction

1.1 The Role of the Voluntary Sector in Cross-sector Collaboration – Research Focus

This thesis explores the role of the voluntary sector in an NHS Multispecialty Community Provider (MCP) vanguard project called Wellbeing Erewash (WE). WE was based in Derbyshire, England, and ran from April 2015 until March 2018. The project existed within a context in the United Kingdom of austerity politics; an acknowledgement of the increasingly difficult and ‘wicked’ (Rittel and Webber, 1973) problems facing society; and the emphasis in much of the extant social policy that the voluntary sector was part of the solution to these issues. Working collaboratively with the sector was put forward in policy as the way that these solutions could be leveraged into public service delivery (see for example NHS, 2014). Chapter 2 – Context provides more detail in relation to the project itself and Chapter 3 – Literature Review details the history of the public and voluntary sector working together in the UK.

As someone who has worked in the voluntary sector for many years, I have personal experience of collaborative voluntary-public sector projects and some of the positives and negatives of such a way of working. Often, I and my colleagues experienced frustration over the seeming lack of practical implication of policy promises. These personal experiences form part of my axiology – my own background and reason for embarking on the research - which is detailed in Section 4.4 of Chapter 4 – Research Design. My previous experiences acted as ‘shortcuts’ (Moore, 2000) in relation to my interest in the topic and access to the research context. These shortcuts led to the initial aim of the research – to find out how the voluntary sector worked in the Wellbeing Erewash project. The final research questions described in Section 1.4 developed iteratively through the process of carrying out the research.

‘Cross-sector’ in this thesis refers specifically to the organisations involved in the WE project, and therefore to the public and voluntary sectors. The makeup of the voluntary sector in the UK is itself
widely debated in the academic literature (Osborne and McLaughlin, 2004; Alcock, 2010; Macmillan, 2013; Milbourne, 2013; Windrum, 2014). It has been described as a “loose and baggy monster” (Kendall and Knapp, 1995, p.66) and, in a global context, as defined by its diversity (Will et al., 2017). Section 3.2.1 of Chapter 3 – Literature Review explores this issue further. For the purposes of this thesis the sector is defined as:

"a space of organisational activity located between the state, market and private familial spheres comprising a diversity of organisational types including charities, social enterprises, faith, community and grassroots groups." (Rees and Mullins, 2016b, p. 3)

Collaboration is also a complex subject, however I take the definition given by Huxham and Vangen (2005) as a starting point as their work is itself focussed on practice; collaboration for the purposes of this thesis is therefore “any situation in which people are working across organisational boundaries towards some positive end” (p.4).

1.2 Approach

Having a focus on practice necessitates an approach to the research that is compatible and consistent across all elements of its design. This is vital both for the research itself to be seen as a valuable contribution to the ‘academic cannon’ and for the insights generated from it to ‘make sense’ within the practice context from which they were developed. In order to maintain this consistency of focus, I have adopted the ontological and epistemological position of Pragmatism. Chapter 4 – Research Design covers the implications of this position. To summarise, pragmatism attempts to close the gap between theory and practice by focussing on the practical implications of research. It allows for the researcher to be directly situated in research processes and for the values of the researcher to be foregrounded, for the use of multiple methods of gathering data, and for ‘truth’ claims to be judged as those that enable successful action.

Two important aspects of this approach should be emphasised by way of introduction to the content of this thesis. Firstly, the foregrounding of my position as both researcher and participant in the research – which will be explained further in the next section – is important because of my previous
Chapter 1 Introduction

experience and good relationships with practitioners in the voluntary sector. It also enabled my approach through providing access to practice contexts and legitimated the interventions I enacted on a day-to-day basis during my data collection. This is consistent with the action research and ethnographic methodologies that were adopted, in the style of what I refer to in the thesis as ‘engaged research’\(^1\). Secondly, such an engaged approach differentiates my research from much of the previous work into voluntary-public sector collaboration which has tended to rely on interpretative approaches that capture ‘espoused theories’ (Argyris and Schön, 1974) of practitioners – what they say they do. My research, on the other hand, does more to capture practitioners’ ‘theories-in-use’ (Argyris and Schön, 1974) – what they actually do. Such an approach offers access to insights that can’t be generated in other ways (Eden and Ackerman, 2018) and as a result, the findings and recommendations of research that focuses on what happens in practice are more likely than other approaches to fit both with practitioners’ understanding of the research context and their ability to implement change.

1.3 Researcher Position

My position in relation to this research was one of a ‘friendly outsider’ (Greenwood and Levin, 1998). I was heavily involved in the research context, but I was not a complete ‘insider’ researcher as my involvement did not extend either before or after the research process (Coghlan and Brannick, 2010). Despite having worked in the area previously I was not directly involved in the implementation of the Wellbeing Erewash project. I was ‘inside’ owing to the relationships I had and the access that was granted to me, but ‘outside’ in the sense that I was able to intervene without fear of personal or organisational reprisal locally, was able to remove myself from the research context when I chose to,

---

\(^1\) The use ‘engaged research’ in this thesis is distinct from Van de Ven’s (2007) use of the term ‘engaged scholarship’. I am referring specifically to the range of methods used, rather than broader approach to research design, although both have a commitment to practice. As such, I am not claiming to have adopted Van de Ven’s approach.
Chapter 1 Introduction

and, maintained a foot in the academic world through regular contact with my supervisors and academic peers. In addition, my position did change depending on the particular situation or aspect of the research context I was involved in at any one time which necessitated an approach to reflexivity that helped to identify the different impacts of this on my data collection. Section 4.7.8 of Chapter 4 – Research Design covers researcher position in greater detail.

1.4 Research Questions

As is common in engaged research approaches, the questions within this thesis emerged iteratively over time as the process of research took place. I began with a ‘central research question’ (Wengraf, 2001), which was to investigate what was happening in relation to how the voluntary sector was working in the Wellbeing Erewash project. Some early engagement with the academic literature led to the development of several sub questions as detailed in Section 4.7.1. These acted as cues for the initial research approach and early stages of data collection, building on the ‘shortcuts’ I had developed from practice described in Section 1.1. My approach to data collection was holistic and open to change as Section 4.7.2 details. The process of developing the initial question into the final questions for this thesis began in earnest during the analysis of the data, which is described in detail in Chapter 5 – Analysis. That analysis broadly followed Braun and Clarke’s (2006) ‘Six Phases of Thematic Analysis’, and the codes and themes developed through this in turn influenced the three research questions for this thesis.

These are as follows:

1) What was the role of the voluntary sector in Wellbeing Erewash?

2) How did trust, power, and control play out in this collaborative context?

3) In what ways was the voluntary sector able to contribute to leadership and ‘make things happen’ in the project?

As reflected in the title of this thesis, the first question acts as the main research question. It serves two main roles in relation to the other questions. Firstly, it provides the opportunity to look in an
holistic manner at all of the factors related to voluntary sector involvement in the project, as such it links closely with the ‘research purpose’ and ‘central research question’ (Wengraf, 2001) explored in more detail in Section 4.7.1. Secondly, it provides the starting point through which to consider specific aspects of the data that emerged during the process described in Chapter 5 – Analysis. These aspects are explored through the second and third research questions that focus on aspects of trust, power, and control (second question) and leadership (third question) respectively. The questions are presented in this order because answering the first is both a necessity in understanding the data in order to move on to the analysis of the specific aspects of questions two and three, and helps to provide the reader with a narrative that ‘makes sense’ when reading the thesis. It is also an accurate representation of the how the analysis developed, from the general to the specific. Finally, having question 1 as the main focus allows me to revisit and make conclusions about the title of the thesis – ‘the role of the voluntary sector in cross-sector collaborations’ – as explored in Chapter 8 – Conclusion.

The definitions of both the ‘voluntary sector’ and ‘collaboration’ adopted in this thesis have been described in the previous section and are also contained within Table 1-1 above (p. xiii), however, it is important to clarify briefly what is meant by several other elements inherent in these questions in order to position the research and foreground the relevant literature that will be explored in Chapter 3 – Literature Review.

Firstly, the notion of ‘trust’ grew out of practice in that it was referred to extensively by participants but was never defined. The use of the term in practice primarily related to being able to have confidence in others – individuals, organisations, or sectors – to work in a way that was compatible with expectations. Participants also identified differences inherent in the ways of working between voluntary and public sector colleagues as an important element of trust. Trust in this thesis is therefore used to refer to a means of coping with uncertainty (Bachmann, 2001) both between organisations and the people within them. In addition, it is also used in relation to the notion of different ‘traditions’ (Bachmann, 2001) of trust across the voluntary and public sectors, based on
those organisational and personal elements. Section 3.3.1 of Chapter 3 – Literature review - explores trust in more detail.

Secondly, the notion of ‘power’ similarly was not defined within the practice context and was used in a variety of different ways that conform with much of the academic literature around the subject (see Section 3.3.2). This thesis adopts Lukes (2015) notion of the three dimensions of power: the ‘overt’ first dimension of A’s power over B to do something they wouldn’t have otherwise done; the second ‘covert’ dimension which is related to who has a say in what, when and how issues are discussed; and the third ‘latent’ dimension of social and historical factors that shape expectations of both the powerful and powerless. Power in this thesis is also not treated as a finite resource, rather, as Mary Parker Follett (1925) suggested, power can be jointly developed and co-active.

Thirdly, ‘control’ in this thesis is primarily related to the notion of ‘power over’ the aspects of Wellbeing Erewash as a collaborative project (see Huxham and Beech, 2008), crucially, convener power and power over resources. Control therefore refers to the direct ability to make decisions about aspects of voluntary-public sector working. Crucially, within this thesis, trust, power, and control are not treated as separate elements but as fundamentally linked together within collaborative contexts (Bachmann, 2001; Ran and Qi, 2018). Furthermore, trust and power are ‘entangled twins’ (Ran and Qi, 2018) that both act upon control. Section 3.3.4 explores these linkages.

Finally, the definition of ‘leadership’ within this thesis is adopted from the work of Chris Huxham and Siv Vangen in relation to leadership within collaborations (see Huxham and Vangen, 2000a; 2005; Vangen and Huxham, 2003b). Their definition focuses on ‘making things happen’ in practice contexts. This itself is informed by the work of Hosking (1998) who stated that leadership equals "processes in which flexible social order is negotiated and practiced so as to protect and promote the values and interests in which it is grounded" (p.315, in Huxham and Vangen, 2000a, p.1161). This conception allows for emergent and informal leaders to play a role, alongside those in hierarchical leadership positions. This is particularly important for the voluntary sector as it both has less access to hierarchical aspects of leadership in collaborative contexts and has traditionally been seen as defined
by shared and distributed approaches to leadership, in contrast to the NHS, as Section 3.4 of Chapter 3 – Literature Review explores.

1.4.1 Research Objective(s)

My primary research objective at the start of the research (as represented in the ‘central research question’) was to provide a detailed account - or ‘thick description’ (Geertz, 2005/1972) - of how the voluntary sector was involved in Wellbeing Erewash. Additional objectives were as follows:

- To explore the position of Erewash Voluntary Action as the ‘named lead’ for the sector in policy and in practice.
- To explore wider assumptions made about the role of the voluntary sector that manifested within the project.
- To make a positive impact in practice through carrying out the research, informed by the traditions of engaged research.

In keeping with the iterative approach taken (see Chapter 4 – Research Design), subsequent objectives developed during the course of the research. These relate back to and progress the primary research objective and are reflected in the other research questions. These were informed by what ‘jumped out’ (Miles and Huberman, 1994) during analysis and are as follows:

- To explore the notion of ‘control’ present within the data and its wider implications, particularly around trust and power dynamics.
- To examine the notion of ‘leadership’ presented within the project and explore whether the voluntary sector were able to enact leadership.

1.5 Contribution of the Research

In completing the research within this thesis, I set out to make a contribution to knowledge that was practice-based, and that focussed specifically on the voluntary sector. The impetus for the research came from my own experiences in practice and the interactions I had with my fellow practitioners. As
a result, I had a personal commitment to make a contribution to practice both during the process of the research itself with practical research interventions, and with the legacy of the research in both practice and academic knowledge. As Section 4.7.5 of Chapter 4 – Research Design – makes clear, the validity of the research is tied to whether its findings ‘make sense’ in a practice context. The thesis therefore contributes to knowledge in three distinct areas: to the academic literature; to practice; and to the relevant policy areas. These three distinct aspects overlap in relation to both how the research was carried out, and how the findings of the research can be implemented from a practical point of view. Section 8.3 in Chapter 8 – Conclusion, explores the contribution of the research to these three areas in greater detail.

In relation to the academic contribution of the research, I draw on Albareda’s (2018) notion of ‘transmission belt’ organisations (Albareda, 2018) to conceptualise the twin demands placed on the voluntary sector as both a ‘route in’ to communities and a ‘voice for’ them. I contribute understanding to how this twin role works in practice and how the tensions inherent in this risk damaging the relationship voluntary sector organisations have with their service users and wider communities. In turn this risks damaging the sector’s ‘comparative advantage’ (Billis and Glennerster, 1998). Secondly I identify different traditions of trust and power inherent in the ways of working of both the NHS and voluntary sector, drawing on Bachman’s (2001) notion of the interrelation between these two concepts at both a micro and macro level, particularly as they act upon notions of control. This is particularly important as these different traditions can prevent the different sectors from working together successfully. Identifying an inherent difference in the voluntary sector also adds empirical evidence to debates in the voluntary sector literature around the uniqueness of the sector itself. Finally, in relation to leadership, I adopt insights from the literature on collaborations to identify how the voluntary sector was able to ‘make things happen’ (Huxham and Vangen, 2000a) in the Wellbeing Erewash project through both working in the spirit of collaboration and through more directive or authoritative means. This contributes to a more nuanced understanding of leadership in the voluntary sector as a whole that goes against previously held notions of collaborative leadership.
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in the sector as focussed primarily on the ‘positive’ or facilitative aspects of its enactment (Hodges and Howieson, 2017).

1.6 Structure of the Thesis

This section will give an overview of the structure of the thesis and provide a brief outline of each chapter. This introductory chapter has provided the initial background for contextualising the subsequent chapters detailed below, including the general context and impetus for the research; the methodological approach taken and my position as researcher within this; the specific research questions that this thesis answers; key terms and abbreviations that are important throughout the thesis; and a note on the contribution that the thesis makes across academic, policy, and practice domains. All of the aspects of the thesis introduced in this first chapter are explored in much greater detail in the chapters that follow. Specifically:

Chapter 2 – Context – describes the practice context in which this research is based. It briefly explores the areas of public service reform that led to the creation of the Wellbeing Erewash MCP vanguard project (WE). The complexity of current NHS policy is demonstrated and the key aspects of policy that contributed to WE on both a local and national scale are discussed. In addition, the local voluntary sector context is introduced, with a particular focus on Erewash Voluntary Action as both the ‘named lead’ for the voluntary sector within WE, and the host organisation of my research. Chapter 2 also contains an overview of the structure of the Wellbeing Erewash project itself including how funding was allocated, how the project was governed, and the different ‘workstreams’ within it.

Chapter 3 – Literature Review – Chapter 3 explores in more detail the aspects of public service reform in the UK that have included the voluntary sector first introduced in Chapter 2. This includes the development of both New Public Management (NPM) and New Public Governance (NPG), and the ongoing impact of austerity politics. In particular, these developments have led to an increase in voluntary sector involvement in public service delivery, and a changing relationship between the public and voluntary sectors within these collaborative contexts. This chapter also explores trust,
Chapter 1 Introduction

power, and control in collaborative contexts and in particular the potential for different traditions to exist within cross-sector working. As all three of these subjects have vast academic traditions, the review of literature concentrates on work that has a focus on collaborative contexts and emphasises the interactions between them in practice. This chapter explores the literature on leadership that has focussed on the voluntary sector and its interactions with the NHS including the competing ‘institutions’ (Currie et al., 2009) of distributed and hierarchical leadership within the latter. It also draws insights from the collaboration literature to detail how the voluntary sector is able to ‘make things happen’ despite ongoing dominance in a hierarchical sense from the NHS. This section also makes reference to relevant debates in the wider leadership literature. It is important to emphasise that, due to the iterative nature of the engaged research approach applied within this thesis, the literature review developed alongside the data collection and subsequent analysis of findings. As such, the literature described in this chapter is that which is relevant to findings that emerged as a result of systematic approach to analysis, and reflection on these findings as they related to relevant academic literature.

Chapter 4 – Research Design – this chapter explores all aspects of the approach of this research, including the ontological and epistemological position that was adopted, and the influence of my own axiology on this. It situates this philosophical approach as the most relevant to the aim of the research to explore and develop insights from practice. This basis informs the methodological approach taken which is detailed in Section 4.7 – Methodology. This section describes the iterative development of research questions and how the focus on practice led to a broad approach to data collection methods and the resulting data that was collected. It explores the approach taken to validity, sampling and triangulation in relation to the aspects of Action Research and Ethnography that were adopted for the purposes of the research methodology. Finally in this chapter, my position as a researcher is explored and the crucial role that reflexivity played in enabling me to explore and understand this position is detailed in relation to both the practice of reflexivity in engaged research approaches and how I adopted this in my own practice as a researcher.
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Chapter 5 – Analysis – details the systematic approach to analysis that was taken in order to make sense of the diverse range of collected data. Braun and Clarke’s (2006) Six Phases of Thematic Analysis are described and the adaptation of their approach to my research is made clear, including how initial coding of the data took place, and how themes were developed into initial findings, providing the background for Chapter 6 – Findings. The role of reflexivity in this stage of the research is also described, in order to emphasise that the development of findings was an iterative process. This is also important to relate back to the iterative development of research questions described in Chapter 4 – Research Design. The approach taken to ensuring quality in analysis is also made clear, following Miles et al., (2014).

Chapter 6 – Findings – describes the outcome of the systematic analysis of data. It aims to provide a thick description of the practice context and the themes that emerged from the investigation of the voluntary sector’s role within it. It starts to categorise these findings in relation to the themes and the research questions that developed alongside them. The role of Erewash Voluntary Action is particularly highlighted as they were both the ‘named lead’ in policy documents for Wellbeing Erewash, and because in practice they were the primary organisation used by the project to engage with the voluntary sector. As referenced in relation to Chapter 3 – Literature Review, the findings of the research (and the analytical process that led to them) should be read as part of an iterative process of data collection, analysis, review, and reflexivity.

Chapter 7 – Discussion – this chapter relates the themes developed in the findings in Chapter 6 to the literature reviewed in Chapter 3. It explores the extent to which that literature is able to explain the findings of the research and details where there are gaps in understanding. It provides the detail through which to answer the research questions in Chapter 8 – Conclusion, by first establishing the general role of the voluntary sector in Wellbeing Erewash, including how Erewash Voluntary Action acted as both a ‘route into’ and a ‘voice for’ communities; how the NHS maintained control over resources and were emboldened by their power as convener of the project, side-lining the voluntary sector from certain aspects; how this control over resources and the collaboration as a whole
demonstrated different interactions of trust and power, which both also act upon control; and how leadership in the project was a complex mix of approaches that both attempted to share and distribute leadership roles and acted to isolate leadership in authoritative hierarchies. Overall, the emphasis of this discussion is the difficulty faced by practitioners in attempting to work collaboratively across organisations, and sectors, despite an increasing emphasis on the importance of doing so.

**Chapter 8 – Conclusion** – this final chapter revisits the research questions detailed in previous chapters and specifically answers them in relation to the findings of the research, relative to the existing academic literature and the contribution of my research. It details the contribution of this thesis in relation to the role of the voluntary sector as ‘transmission belts’ (Albareda, 2018) and the potential for competition in this space to impact on the sector’s relationship with communities and service users; the interactions of different traditions of trust, power, and control across the voluntary sector and NHS that make collaboration difficult; and the way the voluntary sector can enact leadership in such contexts, with the potential this has for a wider impact on leadership in the sector. This chapter also continues the focus on reflexivity found in previous chapters to reflect on the overall approach to the research, its strengths, and its limitations. It ends by focussing on the vast potential for future research that exists to explore the role of the voluntary sector in cross-sector collaborations.

### 1.7 Summary of Introduction

This introduction has provided a brief overview of the overall context, content, and structure of the thesis. It has set out the relevance of the research to both the academic literature and to practice and provided insight into the contribution that the research makes to both areas, and to policy development. Both the philosophical and methodological approaches have been described, including the engaged methods adopted and my position as both researcher and participant within the practice context. Key terms have been defined and the importance of reflexivity to the iterative research
Chapter 1 Introduction

process has been emphasised. Finally, an overview of each chapter of the thesis has been provided, giving a brief description of the content to come, and providing a level of expectation in relation to the overall narrative of the thesis.

The next chapter will describe in detail the context of the research, including national and local policy developments in both the NHS and voluntary sector that led to the creation of the Wellbeing Erewash project.
Chapter 2. Context

2.1 Introduction to Chapter 2

The Wellbeing Erewash project came into existence as a result of a variety of different policy drivers, within an NHS that had experienced significant recent changes. In addition, the voluntary sector itself has gone through a transformation in recent decades in terms of its working relationship with public sector bodies.

Because of the broad range of changes to the delivery of public services both generally and specifically in the NHS it is important to give a brief overview in this context chapter before exploring in more detail in Chapter 3 – Literature Review. The chapter will also give an overview of the national context for both the voluntary sector and NHS, including the key policy developments that contributed to the establishment of the Wellbeing Erewash project and the broader state of the voluntary sector. This is necessary in order to situate the Wellbeing Erewash project within historical and contemporary developments and to provide the reader with an understanding of the current challenges the voluntary sector faces. I will then explore how these national aspects are reflected in the local Erewash context and provide detail on Erewash Voluntary Action as the key organisation in the sector in relation to the project. I will also explore in detail the Wellbeing Erewash project itself including the funding and governance arrangements, structure of different aspects or ‘workstreams’ of the project, and the related ‘Health as a Social Movement’ work. This is particularly important in order to draw attention to which aspects the voluntary sector was and was not involved in.

2.2 Public Service Reform in Recent Decades

A key driver of change within public services from the 1980s onwards has been the desire to decrease bureaucracy and introduce efficiencies through increased competition between different service providers (Bovaird et al., 2014). This drive was positioned as an effort to combat the 'waste' of the
Chapter 2 Context

Public sector and its tendency to produce an inefficient, expensive and low-quality service (Dawson and Dargie, 2002).

These changes have been conceptualised as an era of 'New Public Management' (NPM) (Hood, 1991; McLaughlin and Osbourne, 2002a, 2002b), however whether this truly constitutes something 'new' or is simply a reframing or extension of historical behaviours and traditional management methods has been debated (McLaughlin et al., 2002; Kettl, 2005). Nevertheless, we have certainly seen the reframing of roles towards competitive processes, such as commissioning (DoH, 2007; Macmillan, 2010; Bovaird et al., 2012; Miller et al., 2013; Rees, 2013). More recently, writers have started to suggest the NPM era has been itself replaced by a period of 'New Public Governance' (NPG) (Osborne, 2006) and with it a focus on co-produced, bottom-up initiatives in place of command and control bureaucracy (Howlett et al., 2017). However, within this, NPM ideals have been found to be ‘alive and well’ (Hemmings, 2017). Chapter 3 – Literature Review explores these developments in greater detail.

It is therefore reasonable to surmise that different relations between the public sector – particularly the NHS - and other sectors have existed in different forms throughout history and that have ebbed and flowed depending on a variety of different factors (Exworthy et al., 1999).

Within this context and after the reforms initiated by the Health and Social Care Act (2012), we now have an NHS in England that comprises a wide range of competing service delivery organisations, operating under the umbrella of the NHS brand; an even wider range of commissioned organisations that operate under NHS guidance but not NHS control (including in the private and voluntary sectors); the purchasing of the majority of services by local ‘Clinical Commissioning Groups’ (CCGs); and the existence of NHS England as the overall body that produces policy and has ultimate say over budgets. NHS England also directly commissions some services. Of note within these structures is that often the NHS organisations that deliver services commissioned by CCGs are also themselves commissioners of services from other providers, often from the private or voluntary sectors.
Chapter 2 Context

2.3 The National Voluntary Sector Context

The context in which voluntary sector organisations operate has changed significantly over the last twenty years (for an overview see Maier et al., 2016). This has included new organisational forms under the blanket of ‘social enterprise’ such as Community Interest Companies that bring with them new governance challenges (Spear et al., 2009). Organisations have benefitted from the contracting out of public services both to generate additional funding and to continue to deliver services in relation to their ‘mission’. The increased emphasis on the voluntary sector delivering public services that has been seen in UK policy since the late 1990s marks a particularly important change and brings with it a variety of new questions and concerns around how this is organised and implemented (see Rees and Mullins, 2016a).

Figure 2.1 - Voluntary Sector Total Income

MATERIAL REDACTED

This contained a graph produced by NCVO that showed voluntary sector income rising from 2000 to 2016.

All NCVO data can be found at: https://data.ncvo.org.uk/

(Source: NVCO, 2018)

Overall funding in the sector remained relatively flat from the financial crash of 2007/8 until around 2014/15 when income began to rise – see Figure 2.1 above (p.16) – however that rise was largely due to the increase in income from individuals, rather than any targeted state investment – see Figure 2.2 below (p.17). Income from government actually fell in 2014/15 (NCVO, 2018).
**Figure 2.2 - Breakdown of Voluntary Sector Income Sources**

**MATERIAL REDACTED**

This contained a graph produced by NCVO that showed the variation in voluntary sector income (2001-2016) from various areas:

- The public
- Government
- Investment
- Private sector
- National Lottery

All NCVO data can be found at: https://data.ncvo.org.uk/

(Source: NVCO, 2019)

**Figure 2.3** below (p.17) shows that the government funding that remains is increasingly through contracts to deliver services, rather than grant arrangements, which has led to concerns around the sector’s independence and quality of services (Carmel and Harlock, 2008; MacMillan, 2010, NCVO, 2016). Voluntary sector organisations’ relationship with the commissioning structures for contracted services has not always been a smooth one (Rees et al., 2016).

**Figure 2.3 - Voluntary Sector Income from Grants and Contracts**

**MATERIAL REDACTED**

This contained a graph produced by NCVO that showed voluntary sector income from grants and contracts (2000 to 2014).

The graph shows the reduction in grant income and corresponding rise in income from government contracts.

All NCVO data can be found at: https://data.ncvo.org.uk/

(Source: NCVO, 2018)
It’s also important to note that more than half of the sector’s income goes to the ‘major’ (income over £10million) and ‘super-major’ (income over £100million) sized organisations, despite the fact that they make up less than 3% of the total number of charities (NCVO, 2018). In addition, the ‘super major’ category has been steadily increasing in recent years, suggesting a concentration of increased funding towards the top end of the sector.

Despite the overall rise, there have been significant cuts to services as a result of the austerity drive of successive governments and the impact of these developments has been uneven, with more deprived areas suffering the most (Beatty and Fothergill, 2014). Increasing demand without an increase in funding has also led to organisational strain (Hardill and Dwyer, 2011; Jones et al., 2016). Obviously, within such a large and varied sector there are differences in relation to funding across regions and organisations (Clifford et al., 2010; Clifford and Mohan, 2016). Half of all English voluntary sector organisations are based in three regions in the south – London, the South East, and the South West – with just under two-thirds of the sector’s assets being in London itself (NCVO, 2018).

These changes in funding circumstances and relationships have also led to changing dynamics across organisations and suggestions that the voluntary sector has adopted some of the same professional tendencies as the public sector and that this threatens the value base of organisations (Billis, 1993; 2010; Dolnicar et al., 2008; Neville, 2010) and the trust placed in them by society (Milbourne and Cushman, 2013).

2.4 The National NHS Context

The NHS in England is very large and complex. It is in constant change and development and as such detailing every factor that influences any particular model or way of working at any one time is a challenge. For the purposes of this research the important elements of national NHS policy are those that referenced or influenced the New Care Model Vanguards. The rest of this section will therefore be structured around a focus on the following:
• The Health and Social Care Act (2012) – this marked a radical reconstruction of the NHS and paved the way for more recent developments.

• The Five-Year Forward View (NHS, 2014a) – first introduced the concept of New Care Models.

• New Care Models, including their structure and piloting the models.

• Multispecialty Community Providers – the type of New Care Model of which Wellbeing Erewash is an example of.

• A note on Sustainability and Transformation Plans (now Sustainability and Transformation Partnerships) as these were introduced during the New Care Model pilot programme and had a significant impact on ways of working.

2.4.1 The Health and Social Care Act (2012)

The Health and Social Care Act (2012) led to a wide range of changes in the NHS in England. Most notably this included the introduction of Clinical Commissioning Groups (CCGs) as the managers and purchasers of a large range of local services. This new structure was designed to give clinicians much more knowledge of, and control over what was purchased and delivered in their local area. The CCGs replaced previous 'Primary Care Trusts' which oversaw care across a wider geographical area than the (theoretically) more community focused CCGs (Checkland et al., 2013; Coleman et al., 2013; Segar et al., 2014). There is evidence to suggest that in reality these changes have not been so dramatic, and that CCGs look very similar in terms of size to the organisations they replaced (King's Fund, 2012). However, what is clear is that the accountabilities involved in the delivery of NHS services have changed, although this may not have been for the better (Checkland et al., 2013). Roles within the NHS have also changed with an increase in the notion of clinicians (particularly General Practitioners) as managers (Segar et al., 2014) and changing notions of leadership (Coleman et al., 2013). Despite this, the fact that these changes are still very recent means that the ‘burden of newness’ has to be overcome before conclusions can be reached about whether this is a fundamental change rather than
a temporary disruption. These changes have also brought with them new roles and identities for NHS workers both clinical and administrational (Segar et al., 2014).

2.4.2 The Five-Year Forward View (5YFV)

More recently we have seen the continuation of this drive towards the 'local' agenda with the publication of the NHS 'Five Year Forward View' (NHS, 2014) - referred to as ‘5YFV’ - which contained within it a variety of proposals aimed at encouraging a longer-term view to the development and delivery of NHS services within a specific value framework and in a context of a changing world. Of note within this document are the emphases on 'local' and 'community' solutions to issues as well as a move away from 'one size fits all' policies. The 5YFV emphasised greater engagement with communities and other stakeholders, an increased focus on prevention, and on empowering patients. The focus on individuals and communities has implications in relation to how NHS engagement with the voluntary sector can be framed as we shall see below. These new developments were part of an explicit reframing of the NHS as a 'social movement' (NHS, 2014, p.14).

The focus on the local aspects of healthcare and the devolution of risk and responsibility for health to individuals and communities appeared to be an explicit attempt to reframe the NHS as an institution that ‘supports’ good health by working alongside partners, rather than an institution that is responsible for ‘delivering’ health. Behind this positive spin is the politics of austerity and an attempt to frame cuts in NHS services as both a drive towards sustainability and as justified in the context of a devolution of control. The lack of funds to support such a transformation in services was noted as a barrier to implementation (Ham et al., 2016) and the fact that an additional £20 billion of funding for the NHS was announced in mid-2018 (BBC, 2018) that necessitated a new NHS ‘Long Term Plan’ in 2019 (NHS, 2019a) suggests that the goals of the 5YFV were not entirely met.
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2.4.3 New Care Models

The 5YFV (NHS, 2014) also first introduced the idea of 'new care models' (NCMs) as a way of delivering targeted care to communities removed from 'one size fits all' policies. There are now 5 types of new care models (NHS, 2019b):

- **Integrated Primary and Acute Care Systems** – joining up GP, hospital, community and mental health services
- **Multispecialty Community Providers** – moving specialist care out of hospitals into the community
- **Enhanced Health in Care Homes** – offering older people better, joined up health, care and rehabilitation services
- **Urgent and Emergency Care** – new approaches to improve the coordination of services and reduce pressure on ‘A and E’ (Accident and Emergency) departments
- **Acute Care Collaborations** – linking local hospitals together to improve their clinical and financial viability, reducing variation in care and efficiency.

The ‘Multispecialty Community Provider’ (MCP) is of most importance for the purposes of this research. For the MCPs – of which Wellbeing Erewash is one – the headline driver is the movement of specialist care out of hospitals and into the community. This includes a move towards larger GP practices, the shifting of outpatient consultations out of hospital settings, more control over budgets and a focus on the use of "the ‘renewable energy’ of carers, volunteers and patients themselves, accessing hard-to-reach groups and taking new approaches to changing health behaviours" (NHS, 2014, p.20). A further focus of the 5YFV is the increased use of information to drive efficiencies (NHS, 2014, p.31).

The principles of the New Care Models were set out in a separate ‘directory of support’ document in 2015 (NHS, 2015a) and are reproduced here – see Figure 2.4 (p.22).
Chapter 2 Context

**Figure 2.4 - New Care Model Principles**

Principles 5 and 6:

5: Voluntary, community, social enterprise and housing sectors as key partners and enablers
6: Volunteering and social action as key enablers

emphasize the roles of volunteers and the voluntary sector in the delivery of NCMs. Certainly, these principles constitute a large focus on the voluntary sector in all its forms and underline the emphasis placed on engagement in the 5YFV. It also links that engagement with leveraging the voluntary sector, and some voluntary sector organisations have been named in the NHS ‘Directory of Support’ for the vanguards (NHS, 2015a).

2.4.4 Piloting the New Care Models

The initial document setting out in detail what the NCMs would look like (NHS, 2015a) was accompanied by a separate document that detailed how they would be put into action as part of the wider implementation of the 5YFV, called 'The Forward View into Action' (NHS, 2015b). Both of these
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documents were a follow up to a call by NHS England for applications to become 'vanguard' sites for the new care models programme and a selection process that was described as "a rigorous process, involving workshops and the engagement of key partners and patient representative groups." (NHS, 2016a).

The first 29 vanguard sites were chosen in March 2015 and were of three different types:

- 9 ‘Integrated primary and acute care systems’ vanguards – these will join up GP, hospital, community and mental health services.
- 6 ‘Enhanced health in care homes’ vanguards – which will offer older people better, joined up health, care and rehabilitation services.
- 14 ‘Multispecialty community provider’ vanguards – which will move specialist care out of hospitals into the community.

In July 2015 8 'Urgent and emergency' vanguards were announced – which aimed to improve the coordination of urgent and emergency care services and reduce the pressure on ‘A and E’ departments – and in September 2015, 13 'Acute care collaborations' vanguards - which aimed to link local hospitals together to improve their clinical and financial viability - were introduced. Figure 2.5 below (p.24) shows the location of the vanguards within England (for further information see NHS 2016a).
£200 million was made available for the vanguards as a whole, although no amounts were guaranteed for any particular areas (NHS, 2016b). Money was allocated in relation to what was felt to be merited in each particular project, with the focus on "providing practical support in order to help [vanguards] realise their plans to improve services for local people" (NHS, 2016b). There is also no specified timeframe for the vanguard project; each had to justify its funding and existence on a yearly basis. It was stated at the time that a significant expansion of new care models was planned for 2017/18 (NHS, 2016i) however, other developments ultimately superseded this.

As Wellbeing Erewash was an MCP vanguard the next section will provide additional detail on this specific new care model.
2.4.5 Multispecialty Community Providers (MCPs)

Although launched in March 2015, specific guidance on MCP implementation was not provided by the NHS until July 2016 (NHS, 2016i). The ‘emerging care model and contract framework’ produced at that point contained a variety of features from the 14 MCPs that had been running for the previous 16 months. It included a large emphasis on building strong relationships and trust as well as a focus on improving integration across service areas (p.4). MCPs were to be ‘built’ from integrated teams responsible for communities of around 30-50,000 people, these hubs were then connected in order to create sufficient scale for larger areas which are in turn now linked to the ‘footprints’ of Sustainability and Transformation Plans (outlined in Section 2.4.6).

The NHS framework (NHS, 2016i) lists 10 ‘essential jobs’ in creating an MCP, which reflect the contextual circumstances of the projects themselves and offer an insight into the approaches to development and leadership within the conceptual foundations of the MCP. Of note is the emphasis on building ‘collaborative leadership’ and engaging the local community (p.7). The framework does mention the role of the voluntary sector at two levels. Firstly, in relation to the ‘whole population’ level of care needs and secondly in relation to those with the highest level of care needs (see Figure 2.6 below – p.26). Although there are no other references made to the sector in the framework, the presence of at least some consideration at both extremes of the level of care needs highlights the need to engage with the voluntary sector in order to deliver the goals of the MCP.
Chapter 2 Context

**Figure 2.6 - Four Levels of MCP Care Model**

As noted above, the NHS is constantly changing and progressing, and this has been suggested as a potential threat to the success of the New Care Model programme:

"Perhaps the biggest challenge is allowing sufficient time for new care models to evolve and mature, given the tendency in the NHS for policy makers to move rapidly from one initiative to the next before evidence of impact has been gathered." (Shortell et al., 2015, p.3). This challenge was made real with the introduction of Sustainability and Transformation Plans.

### 2.4.6 Sustainability and Transformation Plans

The latest aspect of the delivery of the 5YFV is the introduction of Sustainability and Transformation Plans (STPs) throughout the country. These plans involve all local health and care systems (including, in theory, the voluntary sector) in creating a ‘footprint’ that "will help drive genuine and sustainable transformation in patient experience and health outcomes of the longer-term." (NHS, 2016c; 2016d).

There are 44 ‘footprints’ throughout the country, and these are described as:

geographic areas in which people and organisations will work together to develop robust plans to transform the way that health and care is planned and delivered for their populations...of a scale which should enable transformative change and the implementation of the Five Year Forward View vision of
better health and wellbeing, improved quality of care, and stronger NHS finance and efficiency. (NHS, 2016d, p.1)

Within each footprint, care is designed to be ‘place-based’, that is, focusing on the specific needs of communities rather than on individual organisations or services. ‘Places’ vary in size and makeup, depending on the particular needs of local areas but are organised around GP practices. The STPs were in part an attempt to roll back some of the changes introduced in the Health and Social Care Act (2012) (King’s Fund, 2017c; BBC, 2017), and an attempt to end the purchaser-provider split in service development and delivery (Public Accounts Committee, 2017, Q93)

Despite being designed as a process that includes all partners across the health and wellbeing sectors - including social care, private, and voluntary sector providers - the practice of STP implementation has been very much led and controlled by CCGs and NHS England; engagement of other parties has been extremely limited (Alderwick et al., 2016). Because of the 'fit' between the two models, it could be argued that the vanguards and STPs are working towards the same goals but in different ways.

However, attempting to transform a whole system that is still piloting new models of working would seem to be premature and potentially damaging to existing processes. Certainly, the new care models are mentioned in the NHS planning and contracting guidance for 2017-19 (NHS, 2016e), as are MCPs specifically, but there is no reference made to the vanguard pilot projects.

STPs also bring together CCGs in order to have an overview of both service delivery and financial planning across geographical areas and to have a joint responsibility to deliver the aims of the STPs beyond their own budgets and working areas. "each STP will have a financial control total that is also the summation of the individual organisational control totals. All organisations will be held accountable for delivering both their individual control total and the overall system control total." (NHS, 2016e, p.5). In Derbyshire, this has resulted in the merger of some functions of the four CCGs in the county, including the consolidation of previous Chief Executive roles into a single ‘accountable officer’. The guidance in relation to STPs also contradicts some of the emphasis on competition seen...
in the NHS over the past thirty years, stating that: "Right across the country, NHS organisations want
to spend less of their time locked in adversarial and transactional relationships." (NHS, 2016e, p.5).
The aim for STPs was to have all of them in place and ready to launch nationally for April 2017. In
Derbyshire that deadline was met successfully. STPs were rebranded as Sustainability and
Transformation Partnerships sometime during 2017 although the reason for this is unclear.

2.4.7 Summary of National NHS Context

In summary, recent NHS developments nationally have focussed on engagement with communities
and a movement of care out of formal, institutional environments and towards community services.
For the voluntary sector this has meant an increased policy profile as the route into many of these
communities. The New Care Model programme was introduced nationally to pilot these new ways of
working, however the influence of STPs has meant the vanguard projects have been superseded in
the policy agenda somewhat. The next section will consider the local context for both the voluntary
sector and NHS.

2.5 The Erewash Voluntary Sector Context

The large regional variations identified above, and concentration of sector assets and income in the
South of England, leads to the question of what the picture is like in Erewash specifically. This section
will give a brief overview of the voluntary sector in Erewash before focussing on the work of Erewash
Voluntary Action (EVA).

Locally there have been significant threats to voluntary sector funding throughout the time that
Wellbeing Erewash has been in operation. This has included multiple reviews from both the Local
Authority and CCG and has resulted in cuts to funding to a variety of voluntary sector organisations.
Those that do still receive funding are often delivering on one year rolling contracts making medium-
and longer-term planning difficult. A cross-cutting review of spending on the voluntary sector was still
to be concluded at the end of the Wellbeing Erewash project in March 2018. Later in 2018 the CCG
announced cuts to all of the funded voluntary sector organisations in the county that were described as “devastating” by the Local Authority (DCC, 2018); and a “travesty” (Derbyshire Times, 2018), and “potentially catastrophic” (Third Sector, 2018) by voluntary sector organisations.

Despite the uncertainty caused by unstable funding situations there is still an active voluntary sector in Erewash, and this has been bolstered by both attention in policy and practice, including certain targeted investment over recent years. However, the area has been greatly impacted by the changes to the sector described in previous sections. Erewash is in the East Midlands, which has the third lowest number of voluntary organisations of any region of England and the second lowest sector income and asset levels (NCVO, 2018). The East Midlands also has the largest proportion of ‘micro’ (income less than £10,000 a year) organisations of any English region (54%). In relation to government funding, the region has seen the greatest reduction in income of any region in England (see Figure 2.7 below – p.29). Erewash is also a relatively rural area and therefore has additional challenges associated with this, such as economies of scale in service delivery, access, demographic change, and understanding of need (Hardill and Dwyer, 2011; Hardill and Baines, 2011).

**Figure 2.7 - Change in Government Income by Region 2014/15 to 2015/16**

This contained a graph produced by NCVO that showed the change in voluntary sector income by region from 2014-2016. The East Midlands experienced the largest decrease at -32%.

All NCVO data can be found at: https://data.ncvo.org.uk/

In summary, the Erewash area, as part of the East Midlands region has seen a large decrease in income from government sources, and a decrease in overall income, over the last several years. It has a large proportion of ‘micro’ organisations of the type that operate at the ‘community’ level and as
such would seem to be vital to the delivery of ‘community’ agendas such as those seen in New Care Model policy. These organisations are less likely than larger ones to rely on public sector funding for survival, however, demand on their services is likely to rise as other organisations are forced to scale back due to austerity.

The ‘named lead’ voluntary sector organisation in relation to the delivery of Wellbeing Erewash is Erewash Voluntary Action (EVA). EVA is also the organisation in which I was embedded for the majority of my time in the field collecting data. The importance of this organisation to the delivery of the Wellbeing Erewash vanguard, and to the collection of data for this research means that an overview of what they do and how they operate is essential.

2.5.1 Erewash Voluntary Action

Erewash Voluntary Action (EVA) is a voluntary sector infrastructure organisation, a registered charity (no. 1069838) and company limited by guarantee, registered in England and Wales (no. 3537038). EVA consists of Erewash Council for Voluntary Services (CVS) and Erewash Volunteer Centre. EVA is part of a wider informal network of infrastructure organisations across Derbyshire called 3D. EVA works across the borough of Erewash (and sometimes beyond) and as such is not constrained by the boundaries of the Wellbeing Erewash vanguard or Erewash CCG more generally (Figure 2.8 below – p.31); they have approximately 70 formal members and around 300 contacts on their regular distribution list (from notes of VS Forum on 2/11/2016).

Voluntary sector infrastructure organisations exist to support other voluntary sector organisations to make their voices heard, find volunteers, raise funds, develop services, identify new opportunities and stay on top of new legal and policy developments. They also help organisations to work in partnership with others across all sectors, identify gaps in services and help to establish organisations and projects to fill those gaps, provide a collective voice for the local voluntary sector and promote the strategic interests of the sector (Wolfenden, 1978; Osborne et al., 2006; Macmillan, 2010; Alcock and Kendall, 2010).
Figure 2.8 - Erewash Boundaries

Figure 2.9 (p.34) shows the broad range of EVA’s activities; ‘EVA transport – individuals’, ‘EVA shopping project’ and ‘EVA befriending project’ are all examples of direct services delivered by the organisation. Many of the other areas of work represent informal services that, much like across the voluntary sector, exist to address (or help others to address) an unmet need in the community at grass roots level (Hardill and Dwyer, 2011).

EVA describe the two sides of their service as follows (adapted from EVA, 2016):

2.5.2 Erewash Volunteer Centre

Provides support at a local level for individual volunteers and volunteer involving organisations. They have six core functions:
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1. **Brokerage** – matching individuals and groups who are interested in volunteering with appropriate opportunities in the local community.

2. **Marketing volunteering** – stimulating and encouraging local interest in volunteering and community activity.

3. **Good practice development** – promoting good practice in working with volunteers to all organisations; delivering training and accreditation for volunteers, managers and organisations.

4. **Develop volunteering opportunities** – working with statutory, voluntary and private sector groups and faith groups to develop local volunteering opportunities.

5. **Policy response and campaigning** – identifying proposals or legislation that may impact on volunteering; lead and/or participate in campaigns on issues that affect volunteers or volunteering.

6. **Strategic development of volunteering** – as the local experts, act to inform strategic thinking and planning at a regional and national level.

2.5.3 **Erewash CVS**

Supports, promotes, and develops local voluntary and community action through the following five key functions:

1. **Services and support** – promote the effectiveness of local voluntary and community groups by providing them with a range of services which may include access to facilities, procedure and policy advice, information sharing and fundraising support.

2. **Liaison** – encouraging networking between individuals and groups in the voluntary sector and between the sector and local statutory and private sectors.

3. **Representation** – providing opportunities for local organisations in the sector to have their views heard on both national and local policy and encouraging the involvement of voluntary and community groups in shaping services.
4. **Development work** – identifying gaps in service provision and working with groups to develop new and innovative services to meet those needs.

5. **Strategic partnership** – working with local government and other statutory agencies to shape the delivery of services and playing a key role in empowering local groups to take part in partnerships to address a wide range of regeneration, neighbourhood renewal, health and social care, learning and other government initiatives.

EVA has been heavily involved for some time in work with public sector organisations in the local area. Most recently, this has included the ‘Mental Health Innovation Project’ which grew from service user concerns in the local area to become a partnership project between several voluntary sector organisations and the local CCG. Many of the relationships and ways of working formed during this project went on to be leveraged in Wellbeing Erewash both in terms of bidding for the funding for the project and in implementing it once secured.

EVA has links into a broad range of service delivery and policy areas in the local context and as such it was a logical choice for me to base myself with them for the purposes on my research.
Chapter 2 Context

= EXAMPLES OF DIRECT SERVICE DELIVERY

Figure 2.9 - EVA Service Map

(Source: adapted from EVA, 2017a, © Erewash Voluntary Action, used with permission)
2.6 The Erewash NHS Context

Erewash CCG (ECCG) is one of five that are responsible for commissioning services in Derbyshire (4 are based in Derbyshire with Tameside and Glossop CCG based in Greater Manchester but delivering some services across the border into the Derbyshire High Peak area). With a population of approximately 97,000 ECCG is one of the smaller CCGs in the country. There are 12 GP practices within the CCG, and it has a given total budget (including the commissioning and delivery of services) of £125.7m (NHS, 2016f) of which approximately £2.1m is designated for the ‘running costs’ of the CCG (NHS, 2016g). The Erewash CCG area does not cover the same geography as either the Borough or County council and there are some large variations in relative levels of deprivation in the area (see Figure 2.8 on page 31). There are two large towns in the CCG area, Ilkeston and Long Eaton with the main CCG offices in the former. Figure 2.8 also shows the concentration of GP practices in the area (purple crosses) which are grouped around the two main urban areas. The rest of the county is quite rural which can present challenges for service delivery.

In addition to working closely with the other CCGs, Erewash CCG also has to work in conjunction with the local authority – Derbyshire County Council (DCC) – in order to deliver services. DCC have faced significant funding cuts in recent years and this in turn has affected the services that they fund. DCC continue to review their service delivery, including to the voluntary sector, and cuts are planned until at least 2020 (DCC, 2016). The CCGs in Derbyshire also carried out a review of grants to voluntary sector services, commencing in February 2014 (NDCCG, 2016). Unfortunately, these reviews were not carried out together, had different timescales and different priorities. This has implications for services jointly funded by both the local authority and CCGs – which includes Erewash Voluntary Action - in that they find themselves answerable to two commissioners working in different ways. It remains to be seen if the emphasis on collaborative working to be found in the STP and MCP guidance documents (NHS, 2016d; 2016i) influences this. Voluntary sector infrastructure funding was subject to a separate review during 2016 with a commitment made in November of that year to continue funding EVA until the 31st of March 2018. These developments provide the context into which the
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Wellbeing Erewash (WE) vanguard project was introduced. It is a situation in flux which has moving
goalposts and changing priorities. The next section will describe the project in detail.

2.7 Wellbeing Erewash - The Erewash MCP Vanguard

This section will detail the structure of the Erewash vanguard, including the allocation of funding,
governance structures and different ‘workstreams’. It will also detail the specific ‘Health as a Social
Movement’ work that developed within the vanguard. This is particularly important as the voluntary
sector (Erewash Voluntary Action) played a vital role in developing and then running this aspect of the
project.

Having been approved in March 2015 Wellbeing Erewash (WE) was set up during the rest of the year
with many elements running in a shadow form throughout this period. This focussed on staff
recruitment within the CCG. The first community events were held in February 2016, marking the
start of the ‘public engagement’ of the project. Further meetings and consultation sessions were held
over the spring and summer of 2016 and by the autumn the overall structures of the vanguard were
set. This included some additional funds that were generated through a successful application to the
Health as a Social Movement programme. The public facing website was launched in October 2016.

Figure 2.10 below (p.37) shows the key events along the Wellbeing Erewash timeline, from the
publication of the NHS ‘Fiver Year Forward View’ in 2014 to the end of the project in 2018.
2.7.1 Allocation of Funding

The WE vanguard was given a budget of £2.1m (NHS, 2016h) which was spent on new staff roles within Erewash CCG. This included:

- A full-time project lead
- Full-time administrator
- Full-time project worker
- Part of a role for a second project worker, shared with Southern Derbyshire CCG
- An informatics role and commissioning role that were originally funded through the vanguard but subsequently drafted back into the CCG generally
- An accountant – until October 31st, 2016
- An additional worker to liaise with GP surgeries.

Many of these roles (or parts of them) moved back into the CCG during the course of the vanguard, raising questions around project focus. The funding for the vanguard itself is as much as the overall
'running costs' for Erewash CCG as a whole and as such represents a significant increase in staff capacity for the organisation. Funding was confirmed by NHS England on a yearly rolling basis although at times this approval was late.

2.7.2 Governance of the Vanguard

Initially the vanguard was organised around an ‘MCP Structure’ – see Figure 2.11 below (p.38). This figure has been included, despite the difficulty in reading it, for two reasons. Firstly, it is the original representation of the structure of WE; secondly, it is an example of the barely legible presentation of many of the diagrams used in the public facing documents for Wellbeing Erewash. This is problematic in relation to the communication of what the project was and how it worked. Figure 2.12 (p.39) is a partial recreation of this structure to provide clarity for the purposes of this research.

Figure 2.11 - MCP Structure

(Source: Wellbeing Erewash, 2106a*)
Of particular relevance to this research is that the only reference to the voluntary sector in this structure is at the bottom of the ‘Community Resilience’ workstream (left hand green box in Figures 2.11 on p.38 and 2.12 on p.39) which states that ‘additional support’ would come from ‘Project Manager, Community Catalysts x2, Voluntary Sector Manager’.

Along with the importance of the governance structures of WE, the practical implementation of the project was the main focus. This centred around the three ‘workstreams’ in the above governance structure diagrams. The next section will elaborate on the content of these workstreams.

2.7.3 Vanguard Workstreams

The Wellbeing Erewash Vanguard focussed on three areas – or ‘workstreams’ - described in promotional material (Wellbeing Erewash, 2016b) as follows:

- **Personal resilience** – supporting you to be as healthy as you can, to look after yourself and know where to get help when you need it.

- **Community resilience** – making sure support is available – and easy to find – in your local community and encouraging people to look out for each other.
Chapter 2 Context

- **Integrated care** – bringing services together to suit the person, not the organisations involved.

As detailed above, the voluntary sector was confined to contributing to the ‘Community Resilience’ aspects of the vanguard and as a result, the majority of data collected for this research if focussed on this area. The ‘personal’ and ‘community’ resilience aspects of the work, because of their interlinking nature, were eventually combined and have been managed by the same team in an integrated way. The logic of this and what it includes is shown in Figure 2.13 below (p.40).

*Figure 2.13 - Community and Personal Resilience Combined Model*
After its initial development, an overview of these aspects of the vanguard was released in October 2016 – see **Figure 2.14** and **Figure 2.15** below (p.41) (note: VS = Voluntary Sector):

**Figure 2.14 - Wellbeing Erewash Personal Resilience Projects**

(Source: Bains, 2016*)

**Figure 2.15 - Wellbeing Erewash Community Resilience Projects**

(Source: Bains, 2016*)
The overview included detail on each of the elements in the above structures and the progress made to that point. The voluntary sector was primarily involved in the community resilience side of this workstream, the details of each element are as follows:

- **‘Quality for Health’** is a quality assurance ‘kitemark’ for the voluntary, community and social enterprise sector (see: www.qualityforhealth.org.uk).

- The **‘Voluntary Sector Forum’** and **‘Community Development Forum’** were both designed to enable the sharing of information and networking amongst organisations.

- The **Community Links** project – later became the ‘community connectors’ work, aimed at engaging and connecting the local community. This work was funded through the ‘Health as a Social Movement’ initiative (more on this below).

- **Timeswap** is a ‘time bank’ skills exchange programme which allows volunteers to swap time with one another by providing assistance to a person or project and ‘banking’ that time for us at a later date. This was managed by the County Council and the Erewash project worker was recruited in 2016.

The release of this information in October 2016 was more than eighteen months after the vanguard was approved and eight months after the first community events were held.

As referenced above, all of the direct funding from NHS England for the vanguard was spent on staff roles within the public sector. This presents particular challenges for the voluntary sector in relation to whether or not to engage with the vanguard as doing so requires additional personal and organisational capacity that many voluntary sector organisations – particularly the small, community organisations that are seen as key in the overarching policy around new care models - simply do not have. Some additional funds were generated through an application to the Health as a Social Movement (HSM) programme.

To summarise, the voluntary sector was confined in Wellbeing Erewash planning to the ‘Community and Personal Resilience’ workstream and received no direct additional funding as a result of their
involvement. Much of the implementation of the project took place before the involvement of either the voluntary sector or community representatives, with the exception being the HSM work which will be detailed in the next section.

2.7.4 **Health as a Social Movement**

The Health as Social Movement (HSM) project directly builds on the 5YFV which itself referred to the NHS as a ‘social movement’. The details of the project were set out in Nesta’s ‘The power of People in Movements’ report (del Castillo et al., 2016). Nesta is an “innovation foundation” (Nesta, 2019) and registered charity. HSM is positioned as a process of leveraging social movements into the NHS in order to develop and inform it, rather than developing the NHS as a social movement itself, although there are obvious links and the report does refer to the NHS as a social movement. HSM calls for new ways of working, removed from traditional hierarchical structures, and suggests that “new types of power and associated forms of leadership are increasingly being recognised as relevant and potentially complementary; power, which is communal, open, shared and relational.” (del Castillo et al., 2016, p.9). The report (and HSM more generally) is influenced by the work of Brown and Zavestoski (2004) (see del Castillo et al., 2016, p.19).

HSM was a two-year programme, launched in early 2016 to support social movements in health care. It initially worked with six of the new care model vanguards, including Wellbeing Erewash, to “develop, test and spread effective ways of mobilising people in social movements that improve health and care outcomes and show a positive return on investment.” (del Castillo et al., 2016, p.47).

HSM aimed to “shift power to patients and citizens, strengthen communities, improve health and wellbeing, and – as a by-product – help moderate rising demands on the NHS” (NHS, 2016j).

2.8 **Summary of Context Chapter**

In summary, Wellbeing Erewash was introduced into a complex environment characterised by ongoing change in the NHS and uncertainty over funding in the voluntary sector.
• **For the NHS** – national policy had resulted in significant changes to the structures and ways of working of the NHS, including new responsibilities around commissioning services and new organisational forms. On the surface these changes suggested greater local control over service delivery. NHS England was introduced to be responsible for the NHS nationally and has a large role to play in setting policy and monitoring delivery. Key strategy documents produced by NHS England, including the ‘Five Year Forward View’ (NHS, 2014) and ‘New Care Models’ (NHS, 2015a) guidance set the strategy direction to 2020. However, newer developments, in particular ‘Sustainability and Transformation Plans’ have pushed local organisations to coordinate across larger geographical areas. The New Care Model vanguards existed in this environment as pilots of new ways of planning and delivering care but without a clear pathway to feed into newer policy developments.

The Wellbeing Erewash vanguard was allocated £2.1 million of funding annually for three years, which was primarily spent on staff roles. Very little new funding was made available to non-NHS organisations however, the additional ‘Health as a Social Movement’ funding was eventually allocated to Erewash Voluntary Action to deliver. Governance of the vanguard was very much in the hands of the NHS through the ‘MCP Board’, and later ‘Alliance Leadership Team’ meetings, to which the voluntary sector was not invited.

• **For the Voluntary Sector** – the voluntary sector nationally has faced significant cuts to government funding, particularly around grants. Although overall funding has continued to increase across the sector, this has been mainly thanks to individual contributions. Locally, Erewash is part of the East Midlands region that has experienced very large and ongoing cuts to funding within the context of a sector that is smaller in size compared to other areas of England. Erewash Voluntary Action are the named lead organisation for the purposes of Wellbeing Erewash, and they operate in a variety of different ways, including traditional infrastructure roles and direct service delivery. Their previous work with Erewash CCG on the Mental Health Improvement Project has meant that contacts and relationships are in place
that have enabled them to be involved in certain areas of the vanguard project as a
continuation of that previous work. However, their involvement, like the voluntary sector as a
whole, is restricted to the ‘Community and Personal Resilience’ workstream.
Chapter 3. Literature Review

3.1 Introduction to Chapter 3

Chapter 2 – Context - detailed the national and local factors impacting on the creation and implementation of the Wellbeing Erewash (WE) project, focussing on the way that public service reform drove the development of the project itself, and the wider working of both the NHS and voluntary sector. Chapter 4 - Research Design – will detail the inductive, practice-based approach adopted to researching this context. Chapter 6 - Findings will explore the results of that approach. This Literature Review serves to introduce the current literature relevant to the thesis, before Chapter – 7 – Discussion, considers the extent to which this literature is able to explain the findings of the research, and where this thesis contributes new knowledge.

As described in Chapter 1 – Introduction, the research questions for this thesis developed iteratively over time. As such, the literature reviewed in this chapter is included as it provides insight into the themes that emerged during the analysis detailed in Chapter 5 – Analysis and helps to start to answer the research questions that structure this thesis:

1) What was the role of the voluntary sector in Wellbeing Erewash?
2) How did trust, power, and control play out in this collaborative context?
3) In what ways was the voluntary sector able to contribute to leadership and ‘make things happen’ in the project?

I will begin with a focus on the voluntary sector in public service delivery in order to situate the policy context of Wellbeing Erewash as described in Chapter 2 – Context, and to foreground the relevant findings of my research as detailed in Section 6.2. This will include the different contributions the sector can make and where it has historically been missing from key aspects. It will briefly focus on the voluntary sector’s previous work with the NHS specifically – because Wellbeing Erewash was an
Chapter 3 Literature Review

NHS project - and the role of voluntary sector infrastructure organisations because of their unique position in the sector and because Erewash Voluntary Action was a key part of this research.

Secondly, the different aspects of Trust, Power, and Control will be considered, particularly in relation to how these aspects relate to collaborative working, the different traditions of trust and power across the voluntary and public sectors, and the relative lack of power that the voluntary sector has experienced in collaborative contexts compared to public sector partners. The concept of ‘control’ is particularly important because – as Chapter 5 - Findings will detail – it was the term used in the Wellbeing Erewash project to conceptualise the drive towards greater community and voluntary sector inclusion in NHS working, and the desire to alter the dynamics of control was a key driver in the project as a whole. This drive is closely related to concepts of both New Public Management (NPM) and New Public Governance (NPG). Trust and power have themselves been suggested in the literature to both be key influencers on the concept of control (Ran and Qi, 2019). Finally, the literature around leadership in public-voluntary sector relations will be considered as this was highlighted throughout the process of data collection and analysis. It also has important implications for how the WE project was planned and delivered as summarised in Section 2.7. As Chapter 6 – Findings will detail, the leadership aspects of WE were complex, with the NHS seemingly in a dominant position, but with a variety of different approaches identified throughout the research. Therefore, the leadership literature explored below will draw attention to the role that more dominant organisations can have, but also focus on the notion of leadership beyond typical ‘heroic’ or authoritarian models and the complexity of leadership in collaborative contexts.

The review will focus primarily on the literature that relates to the voluntary sector and its role in the delivery of public services specifically, but it also includes insights from the literature around collaborations and cross-sector working that are relevant to the research questions detailed above.
3.2 The Voluntary Sector in Public Service Delivery

3.2.1 Defining the Voluntary Sector

Before embarking on an exploration of the literature relating to the voluntary sector’s involvement in the delivery of public services it is important to consider what the ‘voluntary sector’ is and how we might define it. This serves two roles: firstly it provides a starting point from which to understand the use of the term in the research as a whole, and secondly, it positions the research in relation to the contribution it seeks to make and the academic tradition in which that contribution will sit.

The voluntary sector has proven to be very difficult to define (Billis, 1993; Macmillan, 2013; Milbourne, 2013). Various approaches to voluntary, non-profit, and civil society sectors exist around the world (see Salamon and Anheier, 1997). Often definitions are ‘negative’ in the sense that the sector is defined by what it is not, i.e. ‘non-profit’ or ‘non-state’ (Flyvbjerg, 1998b; Milbourne, 2013; Rees and Mullins, 2016b). Definitions can be ‘woolly’ or overly inclusive so as to break down (6 and Leat, 1997), shift over time (Brandsen et al., 2005), and become ‘blurred’, particularly in relation to the boundaries between sectors (Billis, 1993; Billis and Harris, 1996; Taylor, 2001; Milbourne, 2013).

However, as Alcock (2010) suggests, “blurred boundaries are still boundaries” (p.20) and although definitions may break down at the edges, the central aspect or the general rule of them may still hold firm.

In the UK there are ongoing debates about what to call the sector, what to include in any definition, and whether there really is a sector at all (Knapp et al., 1990; Smith et al., 1995; Alcock, 2010; Macmillan, 2013; Rees and Mullins, 2016b). The adoption of a notion of a consistent ‘sector’ in the face of such diversity is seen as offering certain strategic advantages to organisations within it (Alcock, 2010; Alcock and Kendall, 2010), most notably in relations with other sectors, bodies, and organisations. In addition, there have also been some suggestions that powerful actors have ‘invented’ the voluntary sector in the UK to suit their own needs (6 and Leat, 1997). Extending this criticism further we can suggest that the formation of a ‘sector’ also suits the interests of those who
wish to study and work in it, certainly the field has been ‘booming’ (Will et al., 2017) in recent decades. Further, as Macmillan (2013) suggests, the notion of a ‘distinct’ sector is important to those practicing within it but the boundaries will always be contested and ‘fuzzy’. In contrast to Alcock (2010) Macmillan emphasises these boundaries as points of interest in themselves.

Much of the more recent academic literature surrounding the voluntary sector has been influenced by the policy legacy of the New Labour government of the late 1990s and early 2000s. In particular this includes the adoption and ongoing use of the term ‘third sector’. For Rees and Mullins (2016b) this third sector is defined as:

"a space of organisational activity located between the state, market and private familial spheres comprising a diversity of organisational types including charities, social enterprises, faith, community and grassroots groups." (p. 3)

Although much of Wellbeing Erewash emphasised the role of formal organisations, it was also inclusive of the involvement of service users, individual citizens, groups of volunteers etc. who were not members of a formally constituted organisation. The above definition therefore echoes that used in the context of this research (also see Section 6.2.4) in that it allows the inclusion of less formal organisations than definitions such as that used by Salamon and Anheier (1997).

To highlight the changing use of terms in the sector, Rees and Mullins (2016) go on to note that the term ‘third sector’ has been abandoned by the government since 2010 in favour of the notion of the ‘civil society’ although both terms continue to be used. ‘Civil Society’ itself has many different uses although the most common of these equates it with the third sector (Evers, 2013). More recently, the Civil Society Strategy, produced by the government in 2018 uses the term ‘the social sector’ as a way to refer to charities and social enterprises (p. 69) and the terms are often used interchangeably (see for example Hemmings, 2017). Despite these variations, Chapter 6 – Findings, will show that the term ‘voluntary sector’ was used extensively in the context of this research and as such that is the term that this research adopts. It has also historically been the most commonly used term for the sector in the UK (Kendall and Knapp, 1997).
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This research therefore adopts the definition of the sector as proposed by Rees and Mullins (2016b) above, i.e. that it is organisational activity that exists between the state, market and family, and that is comprised of a diverse range of organisational types, but simply replaces their preferred ‘third sector’ shorthand with the ‘voluntary sector’.

3.2.2 The Voluntary Sector in New Public Management

The way public services are delivered in England has changed significantly over the last 30 years (McLaughlin and Osbourne, 2002a, 2002b; Dawson and Dargie, 2002; Bovaird et al., 2014). Many of these changes centre on the idea that there has been an excessive growth of the welfare state and that the public sector is inherently inefficient, resulting in increased costs, decreased satisfaction, and a lack of quality improvement (Brinkerhoff, 2002). This criticism gave rise to the introduction of alternative drivers such as ‘cost control’ and ‘performance improvement’ (Dawson and Dargie, 2002) and resulted in a more ‘professionalised’ public sector, driven by the panacea of market forces and “founded upon a trenchant critique of bureaucracy as the organizing principle within public administration” (McLaughlin and Osbourne, 2002b, pg.9). These changes took inspiration from the private sector (Brinkerhoff, 2002) and have broadly been grouped together under the term ‘New Public Management’ (NPM). NPM has since become one of the dominant paradigms for public management across the world (McLaughlin and Osbourne, 2002b) and in England, successive governments have championed its development, albeit in slightly different forms (Dawson and Dargie, 2002; Macmillan, 2010; Rees, 2013; Powell and Miller, 2014; Miller et al., 2014; Bovaird et al., 2014).

The voluntary and public sectors have historically had a close relationship and much of today’s welfare state grew out of voluntary sector provision (Harris, 2010; Milbourne, 2013; Alcock, 2016; Coule and Bennett, 2018). There is also a long history of partnership working across the two sectors (Lewis, 1995; Rees et al., 2012; Milbourne and Murray, 2017a). However, a key feature of NPM in the UK was the split between purchasers and providers of services using the concept of ‘Compulsory
Competitive Tendering’ (CCT) (Bovaird et al., 2014) and an opening up of the contracted delivery of public services to non-state organisations, including the voluntary sector. Closer ties with the public sector have meant that the voluntary sector itself has come under the same pressure to become more efficient, business-like, and entrepreneurial (Lewis, 1995; Macmillan, 2011). This amounted to attempts by the Conservative governments of 1979-1997 to ‘professionalise’ the voluntary sector, with funded voluntary sector organisations mainly being restricted to roles as ‘service agents’, and the government maintaining control of the policy agenda (Osborne and McLaughlin, 2004).

In England, these changes have resulted in a funding environment that is characterised by a ‘quasi-market’ (Le Grand, 1991; Lewis, 1995), where competition between providers is seen as generating efficiency and greater choice and where funding is reconfigured from grant-aid to services provided under contract. These developments led to a large growth in funding for public service delivery within the voluntary sector (NCVO, 2016) and a dispersal of risk away from the state and onto organisations contracted to deliver services (Rees, 2013). This “contract culture” (Macmillan, 2010, p.5) has resulted in a reduction in flexible grant funding and an increase in more restrictive and prescribed funding arrangements (Miller and Rees, 2014), as noted in Chapter 2 – Context.

The growth of contracting has resulted in greater control of the state over voluntary sector organisations (Milbourne, 2013), increasing the extent to which the sector is seen as ‘governable terrain’ (Carmel and Harlock, 2008), and leading to concerns that the sector is merely an ‘instrument of government’ (Billis and Harris, 1996). This in turn has drawn into question the trust and value placed in the sector (Egdell and Dutton, 2017). However, the voluntary sector is not simply a passive victim in this process and at times can act in a way that reinforces or even actively encourages these developments for their own strategic benefit (Milbourne and Cushman, 2013; Rees and Mullins, 2016). This highlights the varying levels of power and agency within the sector (6 and Leat, 1997). In particular, there are concerns over the impact NPM has had on smaller organisations (Hunter et al., 2016; Aiken and Harris, 2017), although there do appear to be differences across policy areas (Jacklin-Jarvis and Potter, 2018). Related to the issue of agency, concern has been raised around voluntary
sector organisations ‘chasing the money’ of contracts and losing sight of their organisational missions and focus on service users. This has been termed ‘mission drift’ (Harris and Rochester, 2001; Egdell and Dutton, 2017) and is generally seen as a negative within the sector. However, some have suggested that having a more flexible organisational focus can be a benefit for both organisational survival and to opening up alternative working relationships (Erakovich and Anderson, 2013).

The rise of New Labour in 1997 saw the emphasis shift towards ‘partnership’ between organisations and sectors. The Voluntary sector benefitted in this period from a much greater profile in central government policy (Alcock and Kendall; Macmillan, 2010; Rees and Mullins, 2016a; Milbourne and Murray, 2017a). These developments continued to emphasise the involvement of the voluntary sector in public service delivery (Macmillan, 2010). However, this was not felt across the entire sector as the vast majority of voluntary sector organisations continued to not receive any public funding, particularly smaller and ‘micro’ organisations (Davies, 2011). It is perhaps more accurate therefore to say that there was a ‘love-in’ (Davies, 2011) with the organisations from the sector that were able to position themselves as insiders, or that were accepted as legitimate by public sector funders (Taylor, 2001). This highlights the power that funding has in the voluntary sector both to motivate actions of organisations and to act as a structuring element in definitions of the sector – i.e. publicly funded charitable organisations automatically fall into the category of the ‘voluntary sector’. However, it has been a strategic choice for many voluntary sector organisations to access this funding.

Despite the observation from Macmillan (2010) that an increased emphasis on competition can make collaboration between organisations difficult, the fragmentation of service delivery brought about by competitive commissioning of public services and the diversity of organisational providers that this has created has to some extent had the unintended consequence of enabling structures that have then been strategically taken advantage of to leverage closer working relationships (Sullivan et al., 2006). These closer relationships have in turn increased opportunities for collaboration (Huxham and Vangen, 1996; Rees and Mullins, 2016b).
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The increasing involvement of the voluntary sector in public sector delivery has been justified in relation to certain ‘comparative advantages’ (Billis and Glennerster, 1998; Macmillan, 2016) that the sector is said to have. This comparative advantage is closely tied to the notion of ‘stakeholder ambiguity’ (Billis and Glennerster, 1998), meaning that the gaps between users of services and those in authority can be less than in other sectors. Crucially, this approach emphasises the characteristics of demand, suggesting that service users experience different combinations of financial, personal, societal, and community disadvantage that are more likely to correlate with a different type of organisational response. Specifically, this necessitates a more holistic approach to service delivery that recognises this complexity of disadvantage. Hardill and Dwyer (2011) identify some aspects of this in practice, suggesting that staff in the voluntary sector often work beyond their job descriptions in order to support their clients, blurring the boundaries between their professional and informal roles. Billis and Glennerster (1998) do caution however that there can be downsides to this ‘advantage’, including poor communication, internal tensions between paid staff and clients, and a lack of awareness in organisational governance. They also caution that by accepting money from the state, the sector becomes vulnerable to political pressures that can dilute this comparative advantage and that “Over eager ‘privatisers’ may be destroying the very comparative advantages the sector has to offer” (p.97). Other writers have suggested that the voluntary sector has advantages in relation to its ability to access ‘hard to reach’ communities (Alcock and Kendall, 2010; Billis, 2010); trustworthiness and legitimacy (Carmel and Harlock, 2008; Van Slyke, 2009); greater efficiency and lower costs (DiMaggio and Anheier, 1990); choice (Wolfenden, 1978; Chapman et al., 2010); ability to innovate, flexibility, and independence (Osborne and McLaughlin, 2004); and a unique way of working that is less hierarchical than the public or private sectors (Marshall, 1996). The link the sector has with volunteers is also seen as a unique characteristic (Billis, 2010; Rochester, 2013) and part of a closer link the sector has to communities (Macmillan, 2016). Despite the ongoing popularity of these supposed advantages, actual evidence for them is relatively weak (Knapp et al., 1990; 6 and Leat, 1997) and they have been suggested as having a quality “akin to myths” (Kendall, 2003, p.217). Billis
and Glennerster (1998) themselves caution that, despite being based on decades of research, the notion of ‘comparative advantage’ is theoretical. Nevertheless, public agencies contract with the voluntary sector in part because of assumptions about the voluntary sector – and reinforce them by doing so. This conforms with Macmillan’s (2013) suggestion around ‘distinctiveness’ in that it appears important to argue for the existence of a ‘distinct’ sector for certain people that occupy a place within it. This progresses debates around the ‘strategic unity’ of the idea of the sector in a political sense as suggested by Alcock (2010) and Alcock and Kendall (2010).

Much of the emphasis of the New Labour years in relation to public service delivery centred around increasing choice for service users, an emphasis on local governance and involvement, and a focus on target setting and outcomes measurements to track ‘what worked’ in service delivery. This was wrapped in grander goals of promoting citizenship and civic engagement (Alcock and Kendall, 2010). The emphasis on the ‘local’ agenda – or ‘localism’ (Rees et al., 2012; Woolvin and Hardill, 2013; Milbourne and Murray, 2017b) – included the associated desire to ‘co-produce’ services with both users and communities (Taylor, 2001). This notion of co-production signalled a refocussing on public service delivery as a collaborative effort involving multiple stakeholders in a ‘system’ of provision. This in turn has been marked as a shift away from command style government to a softer notion typified by plurality and inter-dependence, marking a stage of public service provision that has been conceptualised as ‘New Public Governance’ (NPG) (Osborne, 2009).

### 3.2.3 New Public Governance

New Public Governance (NPG) is based on the idea that the needs of individuals should be met by the ‘unit of social life’ closest to them (Brinkerhoff, 2002) and that therefore there should be partnership between administrative agents and users in the production of public services (Rouban, 1999). The state is reframed as a facilitator, in contrast to notions of managerialism (see Table 3-1 below – p.56), and notions of ‘localism’ and associated ‘voluntarism’ are emphasised in central government policy as
the way to increase the resilience of ‘place-based’ (geographic) communities (Woolvin and Hardill, 2013).

With its emphasis on localism and community involvement, the concept of co-production is seen as central to much of NPG thinking, linked to the idea of ‘self-service’ provision – individuals taking responsibility for their own care and support (Howlett et al., 2017) - community engagement, and representation. Co-production itself has a strong academic tradition (see Osborne and McLaughlin, 2004; Brandsen and Pestoff, 2006; Bovaird and Loeffler, 2012; Poocharoen and Ting, 2015; Osborne et al., 2016). It is part of a policy drive to develop public service delivery that is no longer purely top-down but is “co-produced by users and their communities” (Bovaird, 2007, p.846). There is no standard definition of co-production (Joshi and Moore, 2004) and the vagueness around the concept means that the term can be employed by various actors to advance conflicting agendas (Morgan, 2001; Milbourne, 2013; Brunton et al., 2017). NPG also consolidates ‘collaborative’ approaches to societal issues (Ospina, 2016), many of which are conceptualised as ‘wicked problems’ (Rittel and Webber, 1973) that are beyond the capabilities of single organisations to address. These developments under NPG are seen as adding legitimacy to public administration and service delivery through a connection with service users, as well as increasing quality and effectiveness. This in turn has more recently been used to justify saving money in public service provision – ‘doing more with less’ – as I will outline in the section on Austerity below.

Co-production in the UK, in contrast to its origins in the USA, has historically emphasised the involvement of voluntary sector organisations as representatives of communities, alongside individual citizens (Brandsen and Pestoff, 2006), as part of a normative model of partnership as the basis for government-voluntary sector relationships and the modernization of public service delivery (Osborne and McLaughlin, 2004). The logic of co-production is therefore that the inclusion of the voluntary sector in policy design (as well as delivery) is both good in itself in that the sector can represent communities, but also that the sector can in turn facilitate the direct involvement of individual citizens. In addition, the focus on shared responsibility for addressing ‘wicked problems’ is
seen as encouraging collaborative working both within and across sectors (Howlett et al., 2017). As such, NPG is seen as a contrast to some of the principles of NPM that encouraged competitiveness as a driver of efficiency. Table 3-1 (p.56) shows the development of public administration from ‘traditional’ bureaucratic public management, to NPM and then NPG.

**Table 3-1 - Policy Tools and Waves of Public Management Reforms**

<table>
<thead>
<tr>
<th>Focus of delivery</th>
<th>Public Administration</th>
<th>New Public Management</th>
<th>New Public Governance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Main Goal</strong></td>
<td>Subjects</td>
<td>Customers</td>
<td>Citizens</td>
</tr>
<tr>
<td></td>
<td>Legitimacy/compliance</td>
<td>Effectiveness/efficiency and better-quality public services</td>
<td>Legitimacy, inclusivity, and flexible government</td>
</tr>
<tr>
<td><strong>Characteristics</strong></td>
<td>Bureaucratic</td>
<td>Competitive</td>
<td>Collaborative</td>
</tr>
<tr>
<td><strong>Dominant Policy</strong></td>
<td>Direct provision by government</td>
<td>Contracting and commissioning</td>
<td>Co-production</td>
</tr>
<tr>
<td><strong>Dominant Procedures</strong></td>
<td>Rules and management tools</td>
<td>Focus on benchmarks and outputs</td>
<td>Public participation and outcomes, trust</td>
</tr>
<tr>
<td><strong>Accountability Structure</strong></td>
<td>Hierarchies</td>
<td>Market-driven</td>
<td>Multifaceted</td>
</tr>
<tr>
<td><strong>Role of Government</strong></td>
<td>Rowing</td>
<td>Steering</td>
<td>Facilitating</td>
</tr>
</tbody>
</table>

(Source: adapted from Howlett et al., 2017, p. 489)

Despite the apparent differences between NPM and NPG some writers have criticised the latter as a continuation of the former, particularly in relation to the role of the voluntary sector. Murray and Milbourne (2017) draw attention to the overriding neo-liberal notions inherent in both and that although localism, community and co-production agendas appear inclusive, central government maintains a powerful position – people and communities are still being ‘done to’. In addition, the lack of trust in relationships between the voluntary and public sectors means that “the promise of more egalitarian relationships, and voluntary sector hopes of enhanced influence through new models of governance, have proved elusive” (Milbourne, 2013, p. 43). NPG has also been conceptualised as continuing the drive of the state to control the voluntary sector, through creating pressure to
modernise and professionalise (Osborne and McLaughlin, 2004), along with the creation of a resource dependency that comes from more public sector funding, which in turn creates ‘isomorphic’ pressures between the sectors that can undermine the supposed advantages of involving the voluntary sector in the first place – ‘killing the golden goose’ (Rees and Mullins, 2016b; also see Harris and Rochester, 2001; Osborne and McLaughlin, 2004; Egdell and Dutton, 2017). This highlights the issue of power dynamics in any policy implementation, particularly as the voluntary sector tends to be the junior partner in new developments and initiatives (Milbourne and Murray, 2017a; Hemmings, 2017) no matter what model of public administration is providing the impetus. Despite these claims, empirical examples of how this pressure manifests in practice are absent from much of the voluntary sector literature.

Overall, despite the initial promise of NPG ideals, even network, devolved, or localism agendas that imply consensual forms of governance are still reliant upon managerial aspects associated with NPM and “are underpinned by powerful technocratic arrangements and hierarchies, which suppress dissent and displace creativity and trust relationships.” (Milbourne and Murray, 2017b, p.4-5). As such, although the New Labour period was characterised by a large investment in the voluntary sector, this did not come with an increase in trust, and in fact monitoring of spending and delivery increased during this period (Kendall, 2003; Milbourne and Cushman, 2013).

Despite this rather pessimistic outlook, Neville (2010) has suggested negative outcomes are not an automatic or inevitable result of closer voluntary-public sector working, particularly if organisations maintain a diverse funding mix. Larger organisations may therefore be more protected and Hunter et al. (2016) have pointed out the disproportionate negative impact felt by smaller organisations that have a ‘traditional inclination’ to work together (Aiken and Harris, 2017) which has been damaged by, firstly, an emphasis on competition exacerbating rivalries, and secondly, austerity politics which has seen an increase in demand on their services.

Albareda (2018; also, Albareda and Braun, 2019) note the twin pressures experienced by voluntary sector organisations in their work with the public sector. On the one hand they must ensure
representativeness through diverse participation of service users, and on the other hand focus on organisational capacity to influence public sector bodies by producing a consistent message for policy makers. Albareda (2018) suggests this amounts to voluntary sector organisations acting as ‘transmission belts’ in their relationships with the public sector – see Table 3-2 below (p.58).

**Table 3-2 - The Twin Role of Transmission Belts**

<table>
<thead>
<tr>
<th>Organisational Representativeness - Boosting diverse participation amongst members/service users.</th>
<th>Organisational Capacity to Influence - Producing a consistent message for policy makers</th>
</tr>
</thead>
</table>

(Source: Adapted from Albareda, 2018)

The notion of representativeness is particularly important in light of the greater emphasis on the involvement of individual citizens in service design and delivery as seen in the policy agenda described in Chapter 2 – Context, particular in the NHS (Carter and Graham, 2018). Voluntary sector organisations are assumed to be able to do this better than the public sector, however these assumptions have not been tested (King and Griffin, 2019) and are a legacy of the concept and myths of ‘the sector’ itself (Rochester, 2013). Albareda (2018; Albareda and Braun, 2019) suggests most voluntary sector organisations are unable to carry out this twin role – acting as a ‘transmission belt’ – despite a preference by state actors for it in policy.

Albareda’s research focuses on member organisations acting to influence policy at the international level and whether this is reflected in local contexts within nations, and particularly in relation to collaborative service delivery is not known. In addition, their research relies on a quantitative analysis of survey data collected from senior leaders in EU organisations, which is limited in identifying the complexities of day-to-day practice. However, there are parallels between the EU context that Albareda researched and service delivery in the NHS, as the involvement of voluntary sector organisations is an attempt to address the acknowledged ‘democratic deficit’ in both (Cornforth, 2003; Ruane, 2014; Benbow, 2018; Albareda, 2018).

What is clear is that despite the supposed developments of New Public Governance, the legacy of New Public Management is alive and well, and in many ways thriving (Hemmings, 2017).
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financial crisis of 2008 and the austerity governments that have followed in the UK have exacerbated the issues for the voluntary sector identified above, particularly in relation to reliance on public sector funding, greater demands placed on engaging communities, and issues of organisational autonomy. The next section will consider austerity and the impact it has had.

3.2.4 The Impact of Austerity

Since the global recession of 2008 there have been successive ‘austerity’ governments in the UK and along with the strategy of attempting to rapidly reduce the public deficit and cuts to public services generally there has been a “significant retrenchment” (Macmillan, 2011, p.115) in the voluntary sector in England. Initially, the Coalition government that emerged after the financial crisis emphasised the role of the ‘big society’ in addressing social problems. This included an emphasis on government leveraging the voluntary sector by being less directly involved, allowing individuals and communities to find their own solutions to problems. However, as this notion became embedded it emerged that this rhetoric was essentially a justification for wide-ranging public-sector funding cuts and the ‘big society’ agenda had withered by the time of the Conservative government in 2012 (Rees and Mullins, 2016b). The subsequent period marked something of an absence in policy relating to the voluntary sector until the new Civil Society Strategy was produced in 2018 (Bennett et al., 2019).

Austerity politics has created several issues for the voluntary sector. Many of these relate back to the tensions created by NPM and NPG but have been exacerbated by spending cuts and a related emphasis on ‘doing more with less’ (Milbourne and Murray, 2011; Diamond and Vangen, 2017). Firstly, as Milbourne and Murray (2011) describe, despite limited evidence that the contracting culture promoted in NPM resulted in better quality services, the focus on efficiency and competition has been reinforced. They suggest that although the value of smaller, community-based organisations has been recognised, they are still marginalised, silenced through consensual pressure by more powerful actors, and dominated by managerial ideologies. Although Milbourne and Murray (2011)
use data gathered from an experiential learning event, which provides some insight into the actions of practitioners, there is a lack of longer-term, practice-based research in this area.

There is a long history within the public-voluntary sector literature of identifying the issue that often promises made in policy do not play out in practice (Harris and Rochester, 2001; 6 and Leat, 1997) and in an austerity context Milbourne (2009; 2013; Milbourne and Cushman, 2013; Milbourne and Murray, 2017a) has drawn attention to this as an ongoing issue. They note the “considerable mismatch between policy aspirations and local experiences and outcomes, generating disquiet about unanticipated consequences” (Milbourne, 2013, p.143). Milbourne’s research suggests there is not a failure to acknowledge the value of the voluntary sector in delivering public services but a failure in practice to carry this through. Hardill and Dwyer (2011) have drawn attention to how this can potentially impact on voluntary sector organisations. Notably this includes the difficulty in securing ongoing funding that fully compensates voluntary sector organisations for the costs associated with service delivery. Additionally, the ending of funding agreements does not lead to a reduction in demand for that service. Organisations are forced to cover this shortfall through their core funding or reserves. The lack of funding, skills, and other resources that is a feature of austerity would suggest that this will be an increasing issue moving forward.

In addition to a refocussing on competition, austerity has also brought about an associated reemphasis on NPG ideals such as community engagement and coproduction as some sort of ‘holy grail’ for the issues inherent in public service delivery (Osborne and Strokosch, 2013). However, as co-production has been mainstreamed into public administration (Brandsen and Pestoff, 2006) its power to act in a critical sense to improve services has reduced. Rather than challenging public administrators it serves whatever purposes they have (Osborne and Strokosch, 2013). As the voluntary sector has been the main route through which co-production has been enabled in NPG agendas there are similar concerns about the role of the sector itself. Equally, as co-production and a healthy voluntary sector is generally correlated with a healthy welfare state (Bovaird and Loeffler, 2012; Milbourne and Murray, 2017a), cuts to the latter will more than likely impact on the former,
rather than the voluntary sector itself acting as a ‘safety net’ for decreased public sector delivery. This is more likely to impact poorer areas that historically have had an absence of both public and voluntary sector support (Milbourne, 2013).

Within austerity, the twin demands of competition and collaboration exist side by side. This has resulted in an increase in demand on the voluntary sector at the very time funding and capacity is decreasing. Voluntary sector organisations are becoming increasingly risk averse in order to protect what they have and Hemmings (2017) has pointed out the climate of fear that now exists in the voluntary sector in relation to acting as a critical voice towards the public sector. Hemmings’ research is based on longitudinal interview data gathered from a small number of participants and as such further research is needed in order to investigate whether these perceptions play out in practice. Egdell and Dutton (2017) have suggested austerity in the UK has led to a focus on short-term goals and projects at the expense of long-term sustainability, and that the ability of voluntary sector organisations to feed in their knowledge about communities is limited by a focus on competitive tendering, leading to organisations delivering services under contract that they know don’t meet their clients’ needs. However, much like Hemmings’ work, this research relies on the opinions of participants gathered through interviews and focus groups so the question of relevance to practice remains. If we consider Albareda’s (2018) suggestion that the majority of voluntary sector organisations have “severely flawed” (p. 1216) representative functions, it may be that the lack of input into service design experienced by organisations in austerity is due more to internal organisational issues rather than external pressures. Furthermore, there is a question to be asked about whether organisations should be carrying out this engagement and representation role at all and whether it distracts focus and resources from service delivery or ‘mission’. Of course, it may be that both external and internal factors are at play. Further to the compatibility issues between competition and collaboration, Sancino and Jacklin-Jarvis (2016) suggest collaboration and co-production also have a complex and at times incompatible relationship. In an austerity context co-production (Osborne et al., 2016) and collaboration (Vurro et al., 2011) are both touted as the
solution to the issue of doing ‘more with less’ and there is no acknowledgement that they may not fit together.

Milbourne and Murray (2017a) have reemphasised their critical approach to public-voluntary sector relations in recent years, suggesting that larger charities are now being run as corporate entities and are competing against smaller, local organisations that historically have been better placed to engage with communities. This, when combined with an approach to public service commissioning in an austerity context that favours larger contracts and providers means that those smaller organisations - that historically have more of a community focus - are marginalised (Aiken and Harris, 2017; Dayson et al., 2018).

The emphasis on ‘doing more with less’ has also focussed the public sector towards leveraging the advantages of collaborative working between organisations, with an implicit belief in the ‘collaborative advantage’ that can be realised through organisations working together to achieve something they would not be able to by acting alone (Huxham and Vangen, 2005). However, the literature has shown that often collaborations are unsuccessful (Vangen and Huxham, 2003b; Huxham and Vangen, 2004), notably in relation to public-voluntary sector working (Huxham and Vangen, 1996). We also know that public sector workers are often likely to ‘retreat to what they know’ in the face of austerity, rather than seek innovative new solutions to problems (Diamond and Vangen, 2017). This suggests inclusion of non-state stakeholders is likely to be difficult. In addition, Milbourne and Cushman (2017) point out that collaborative relationships can themselves be exploitative, particularly if (smaller) voluntary sector organisations are merely used as ‘bid candy’ by larger and more powerful partners who then ignore them when the funds have been secured.

Milbourne and Cushman level these criticisms towards larger organisations in the voluntary sector, however, with ‘hybrid’ working becoming increasingly prevalent in austerity contexts (Guarneros-Meza and Pill, 2017) it is also the case that powerful state actors are in a position to exploit the voluntary sector in order to compete for the limited funds available to them, including competitive tendering for pilot projects such as Wellbeing Erewash itself. The concept of collaboration is now
ubiquitous in public policy discussions, despite unconvincing performance (Sullivan et al., 2012) and cautioning from the literature that it should not be attempted unless absolutely necessary (Huxham and Vangen, 2005). This has created a pressure – alongside competition - on voluntary sector organisations to conform or lose out on funding (Harris and Rochester, 2001). Collaboration is often put forward in policy as a ‘magic bullet’ (Vurro et al., 2011) however Huxham (1996) cautions that it is not a panacea and that in reality collaborative efforts frequently fall short of their lofty goals. Although austerity politics has created a context that was very different to what came before it, it is not accurate to suggest it is entirely ‘new’. Coule and Bennett (2018) in their historical discourse analysis of policy documents suggest that there are no linear narratives in voluntary-public sector relations, rather, they are complex and a constant struggle. Furthermore, if we consider accounts of the sector before the New Labour period such as that detailed by Kendall and Knapp (1997), they note concerns in the 1970s and 1980s that echo those of today. In particular, that “voluntary agencies, particularly small, local ones, may be marginalized because central government fails to recognize their contributions and local authorities find it increasingly difficult to fund them from their declining resources." (p.268). As a result, we can suggest that although austerity politics creates greater pressure on the voluntary sector, it is not unlike situations the sector has faced before. Rather than creating new pressures it exacerbates those that are a constant feature of public-voluntary sector relations.

3.2.5 The Voluntary Sector Working With the NHS

The majority of the literature above implies the UK public sector is a consistent singular entity. However, there are variations in how the different aspects of the public sector work, particularly in light of austerity politics and significant cuts to some budgets – Local Authorities – while others have been ‘ring fenced’, including the NHS. As this thesis looks specifically at voluntary sector-NHS relations it is important to briefly reference some of the relevant literature in this area.
Despite the historical links between the voluntary sector and the welfare state described previously, the New Care Models initiative, and the Multispecialty Community Provider projects in particular “signal a growing shift towards greater community involvement and collaboration with the voluntary sector” (Turner et al., 2016, p.2). Much of this collaborative work has been ‘upstream’ in terms of services, focusing on prevention of illness and general ‘wellness’ support (Peate, 2013). The policy regarding this is focused either implicitly or explicitly on ‘leveraging’ the voluntary sector, rather than working together as equals (Peate, 2013). However, there are examples of successful NHS-voluntary sector collaborations (Pattison and MacRae, 2002; Reid, 2010) and of the voluntary sector offering advantages in terms of service quality over ‘for-profit’ organisations in comparable healthcare environments (Crampton et al., 2002; Haslam et al., 2019). The voluntary sector is seen as particularly good at meeting the needs of marginalized groups, such as Black, Asian and other Minority Ethnic (BAME) communities, notably in relation to mental health crisis care (Newbigging et al., 2017), however, evidence for this is varied (Miller, 2013). There is also little evidence that collaboration with the sector has improved health statuses or systems in communities (Lasker et al., 2001). Despite this, collaboration continues to be emphasized in healthcare policy and practice although the NHS retains a dominance in certain key service areas (Rees et al., 2016). The re-emphasis on competition seen in The Health and Social Care Act (2012) has been acknowledged as a mistake (Public Accounts Committee, 2017, Q93) and the voluntary sector is seen as key to enabling more collaborative ways of working and the involvement of service users in the co-production of health innovations.

In relation to co-production within the NHS, Morrison and Dearden (2013) and Carter and Graham (2018) both point to a large gap between the policy of engagement and the reality. Thompson et al., (2012) found that ‘lay representatives’ often had to move away from their experiential knowledge and towards the professional paradigms of clinicians in order to appear credible. This institutionalisation of engagement can reduce the radical potential of both individual (Morgan, 2001) and voluntary sector (Hemmings, 2017) participation. Co-production in the NHS also exists as a desire to address the ‘democratic deficit’ at the heart of the organisation (Ruane, 2014; Benbow, 2018),
however, engagement initiatives have often been ‘muddled’ (House of Commons Health Committee, 2007) and troubled by confusion and complexity (Ruane, 2014). Fairlie (2015) suggest initiatives are more focused on resolving bad practice within the NHS itself, rather than the development of new, more effective, and/or more collaborative services. Nevertheless, the voluntary sector is still seen as vital - by both politicians and policy - for the operation of the NHS in England (Cabinet Office, 2018).

3.2.6 The Role of Voluntary Sector Infrastructure

This research was carried out alongside a voluntary sector infrastructure organisation – Erewash Voluntary Action (EVA). Chapter 2 – Context, described in detail the work that EVA does and Chapter 6 – Findings will show the role they played in practice. This section will explore the more general role of infrastructure within the voluntary sector as a whole.

Infrastructure for the sector has a long history, first developing in the nineteenth century with the founding of the Charities Organisation Society (COS) and early twentieth century with the founding of the Council of Social Service that would go on to become NCVO (Coule and Bennett, 2018). However, although the initial focus of voluntary sector infrastructure was national, infrastructure bodies have come to be organised across multiple geographical scales (Walton and Macmillan, 2014). EVA is a ‘local’ organisation, i.e. it works within a boundary that is smaller than a county (and therefore not regional), but that stretches across multiple neighbourhoods and communities. There are now hundreds of such organisations operating in England (Mohan, 2012) although political austerity has led to a decrease in funding for infrastructure organisations and resulted in closures (Milbourne, 2013; Walton and Macmillan, 2014, Aiken and Harris, 2017).

Various definitions of voluntary sector infrastructure exist in both the academic and grey literature (see Wolfenden, 1978; Osborne, 2000; Wells and Dayson, 2010; Mohan, 2012; Macmillan, 2016) however, there are some key characteristics that cut across all of these, specifically that infrastructure organisations provide services, support, and advice to frontline voluntary sector
organisations that enables them to deliver their missions more effectively. They do this through the provision of “physical facilities, structures, systems, relationships, people, knowledge, and skills” (Home Office, 2004, p.15 in Macmillan, 2016, p.109).

Infrastructure organisations have historically also been involved in direct service delivery (Wolfenden, 1978) and this expanded during NPM, particularly within New Labour initiatives. This was not without criticism due to the conflict of interest created between infrastructure organisations and their members (Macmillan, 2011). This conflict has eroded some of the ability of infrastructure organisations to act as ‘honest brokers’ (Windrum, 2014). With the introduction of New Public Governance, infrastructure organisations found their role expanded to include enabling aspects of co-production. This has led to a new role in ‘connecting’ organisations within and outside the sector through collaborative ways of working (Macmillan, 2016) and in enabling public sector connections with communities (Osborne et al., 2006). Carrying out such a role can jeopardise the powerful advocacy role played by voluntary sector organisations (Windrum, 2014), further suggesting a conflict of interest. This has led to concerns regarding the disproportionately large impact on local policy development of a small group of organisations or individuals, particularly as community members often only show an interest in a narrow range of engagement opportunities (Osborne et al., 2006).

This issue feeds into debates around the difficulties inherent in measuring the impact of infrastructure work (Macmillan, 2016) despite reported positive experiences of frontline organisations in engaging with infrastructure support (Wells and Dayson, 2010; Dayson et al., 2018). As much of this research is based on interview and survey data there is a gap in understanding around how this dynamic works in practice.

The focus on communities as promoted in NPG is problematic in an austerity context due to the lack of funding and capacity to carry this out (Hardill and Dwyer, 2011; Milbourne, 2013). Infrastructure organisations are likely to be the ‘go to’ organisations for local public sector workers due to their profile and role in representing the sector. However, there is no guarantee that infrastructure organisations will have the capacity or skills to act as ideal type ‘transmission belts’ (Albareda, 2018).
This creates an additional tension alongside that of having to both support individual organisations –
embrace diversity - and represent the whole sector – encourage unity that is fundamental to the role
of voluntary sector infrastructure.

Mohan (2012) has shown that infrastructure organisations typically only have relationships with
between 10 and 30% of the registered charities in their areas of operation, although as this is a
quantitative analysis the quality of these relationships is not addressed. Johnston (2017) suggests that
the impact of austerity has led to a reduced capacity within infrastructure organisations to meet the
needs of the organisations that they do engage with. In addition, infrastructure organisations find it
difficult to support newer forms of organising that have emerged to meet the demands created by
the reduced scope of public services (Johnston, 2017). Engagement with voluntary sector groups who
are not registered charities is therefore likely to be even lower than Mohan’s (2012) estimate, and
engagement with individual community members will logically be even lower still. In addition, the
new demands placed on representation from communities will require new skills to develop and
support, including a focus on diversity and on different channels for engagement, that the voluntary
sector may not have (Taylor, 2001). This creates conflict with the policy drive to involve voluntary
sector organisations as links to communities seen in both the NHS New Care Models documents (NHS,
2014; 2015a) and more recent Civil Society Strategy (Cabinet Office, 2018).

3.2.7 Summary of The Voluntary Sector in Public Service Delivery

To summarise, voluntary sector involvement in public service delivery has changed markedly in the
last several decades. In particular, reforms driven by New Public Management (NPM) ideals have led
to a large increase in public sector funding of voluntary sector organisations and this in turn has led to
criticism in relation to state control of the sector and ‘institutional isomorphism’ (DiMaggio and
Powell, 1983).

Further to this, concepts associated with New Public Governance (NPG) – the co-production agenda,
involvement of citizens, and wider focus on localism - that have been suggested as a solution to some
of the issues associated with NPM, have themselves been criticised as a continuation of previous problematic initiatives (Milbourne and Murray, 2017a) and "fuelled by New Right notions of dismantling the state and enhancing individual freedom." (Locke et al., 2001, p.199). Nevertheless co-production, like collaboration is seen as something of a ‘magic concept’ in public sector policy (Voorberg et al., 2015), not least because of current government spending pressures and austerity politics (Howlett et al., 2017) that have amplified negative elements of both NPM and NPG. Alongside this, opportunities to collaborate have increased as organisations try to work together to leverage ‘collaborative advantage’, despite evidence from practice that often these attempts fail (Huxham and Vangen, 2005). These collaborations risk damaging the ‘comparative advantage’ (Billis and Glennerster, 1998) of the voluntary sector.

Voluntary sector organisations have seen demands on their services increase whilst funding has fallen, creating a pressure to ‘do more with less’. This includes the twin roles of acting as a ‘route into’ communities and as a ‘voice for’ them, which they may not have the skills or capacity to carry out, despite assumptions in policy (Albareda, 2018). This is in addition to the role of voluntary sector infrastructure – such as Erewash Voluntary Action – already experiencing a tension between sector unity and diversity.

These tensions, alongside the wider issues of NPM and NPG lead to the obvious question of how power works across the organisations and individuals involved. Power is closely related to trust and both act upon control. The next section will consider the literature on these three aspects and how they interact in collaborative contexts.

### 3.3 Trust, Power, and Control in Voluntary-Public Sector Working

Trust and Power are pervasive aspects of inter-organisational working and are closely related to one another (Bachmann, 2001). Control is a function, shared by both trust and power (Ran and Qi, 2019), and is itself closely linked to the NPG co-production agenda (Poocharoen and Ting, 2015; Osborne et al., 2016) through the concept of ‘bottom-up’ control. The role of the voluntary sector in the process
of control is of particular importance in the findings of this research (see Section 6.6). This section will consider Trust, Power, and Control separately before detailing how they overlap in collaborative contexts.

3.3.1 Trust

Trust has a vast academic tradition across multiple disciplines. This research is focussed on trust in voluntary-public sector relations in the UK. However, the literature that looks at trust from the perspective of the voluntary sector in such contexts is quite limited and lacks a robust approach to what is meant by the term. As a result, the literature on trust in inter-organisational collaborations more generally will be introduced to provide additional insights. Trust in this context is about trust between organisations involved in collaboration (and the people within them), rather than public trust in the voluntary sector as an entity.

Much of the research about trust in the voluntary sector makes large assumptions, particularly in contrast to the state, that are illusionary (Rochester, 2013). This refers back to the ‘myths’ of the sector referenced previously. Kendall (2003) refers to a ‘trust premium’ that is experienced by voluntary sector organisations and McGhee et al., (2016) suggest that the sector is a ‘trusted intermediary’ in public service delivery. Rees and Mullins (2016c) note that despite recent issues that have impacted trust more generally, the voluntary sector is still trusted more than either the private or public sectors. None of this research focuses on trust between different sectors, i.e. how they work together.

In its most simple form, trust is a mechanism for co-ordinating the expectations and experiences between two actors, and acts as a ‘useful lubricant’ for avoiding tensions between them (Bachmann, 2001). These tensions arise in voluntary-public sector collaboration between autonomy and accountability. Autonomy is necessary to innovate and respond to changing needs in communities, but accountability is necessary in order to ensure resources are being used honestly and efficiently (Milbourne and Cushman, 2013). The lack of trust between the sectors was touched on above in that
even though funding for the voluntary sector may have increased, autonomy has decreased because of an increase in accountability. As a result, trust between sectors is said to have reduced (Milbourne and Cushman, 2013). However, this ‘reduction’ appears to be based on a romantic idea of a trust-charged past that there is little empirical evidence for. Nevertheless, this approach suggests that the increase in market-style relationships between the sectors as a result of both NPM and NPG ideals, and the imposition of inappropriate performance measures that accompanied these developments, impaired trust between the sectors. Milbourne and Cushman (2013) suggest that there are three aspects of trust that relate to voluntary-public sector working that have been eroded:

**Personal** – related to the notion of integrity and the belief that partner organisations will act in a certain way. This can be undermined by notions of ‘mission drift’.

**Competence** – based on a belief in the ability of others to act in the way they say they can. This can be undermined by operational issues within organisations.

**Motivational** – based on the idea that there are joint opportunities for reward but also joint exposure to failure. This is beyond a notion of benevolence as it assumes a two-way relationship. If that relationship is not there, then this aspect will be undermined. Power dynamics play a crucial role in this, and in trust and control more generally, as the following sections will show.

Trust therefore is a means of coping with uncertainty (Bachmann, 2001). However, in reducing uncertainty trust produces risk – a reliance on the other partner based on limited information. Trust therefore can be ‘misplaced’ or ‘betrayed’. If we could exclude these risks or if decisions were purely based on a cost/benefit analysis, then trust would not be needed. The apparent lack of trust placed in the voluntary sector can therefore be assumed to be the result of a risk averse public sector. There are various mediating aspects that aim to reduce risks such as laws, guidelines, and associational/institutional frameworks or practices. These act as stabilising aspects or institutions which then shape social actors’ behaviours.

Trust then is based on a “fuzzy logic” (Bachmann, 2001, p.347) in that it is not purely a formal calculation but equally it is not just a ‘bet’ either. Instead it is based on a latent calculation that comes
after a disposition or first impetus to trust which is then confirmed in a circular process by a second impetus that takes into account the institutional aspects that reduce risk (Bachmann, 2001). Such institutional factors can be seen in the idea of the voluntary ‘sector’ and the assumptions – or ‘myths’ – about it, particularly in public sector policy. We can suggest from this therefore that the involvement of the voluntary sector is, in part, based on an idea of trust that is itself based on an untested assumption of risk reduction. The pressure these assumptions create in policy mean that we find the voluntary sector named as an important aspect of public sector delivery, in partnership with the state, but little real detail as to how this should be achieved. Smaller voluntary sector organisations are seen as benefitting from higher levels of trust in communities because of their day-to-day contacts with community members (Hunter et al., 2016; Dayson et al., 2018), however, these smaller organisations are less likely to be involved in public service delivery (Milbourne and Murray, 2011).

3.3.1.1 Building and Maintaining Trust

Trust in voluntary-public sector relations is not neat or homogenous (Milbourne and Cushman, 2015) and different relationships can cause different levels of trust. NPM motivated competition and contracting can involve trust but is more likely to rely on hierarchical arrangements, whereas collaborative partnerships are expected to involve trust as a more fundamental element (Rees et al., 2012). Milbourne and Cushman (2013) suggest that within voluntary-public relations activities can take place that simultaneously build and destroy trust. However, Getha-Taylor et al., (2018) note that trust and distrust exist side by side at the same time, working at the individual, group, and system levels. Considering trust and distrust separately from one another is beneficial as it allows for the existence of aspects of distrust even within seemingly trusting relationships, highlighting the fragility of the balance between the two and the ebb and flow between them over time. The balance of various aspects of collaborative working do change over time (Kramer et al., 2018) and Vangen and Huxham (2003a) note that trust within these contexts requires continuous ‘nurturing’ in order to
achieve collaborative advantage. They suggest that some form of initial trust is necessary in order to embark on collaborative relationships – which echoes the notion of an ‘initial impetus’ from Bachmann (2001) above. This is far more likely in a context in which there have been previous good relationships. Vangen and Huxham (2003a) suggest trust in collaborative contexts requires both ‘initiating’ and ‘sustaining’. Initiating trust building requires identifying suitable partners, getting started on some practical work whether aims are agreed or not, and managing risk. Later, sustaining trust requires managing the dynamics of change between organisations, goals, funding etc. and managing power imbalances at play. Managing power is particularly important as trust and power are intertwined. As such, identifying power imbalances – which is a necessary step in order to address them – can lead to a feeling of vulnerability and a reluctance to trust, particularly for small voluntary sector organisations involved in such relationships. However, conversely, high levels of trust can overcome power imbalances (Vangen and Huxham, 2003a). Reporting burdens can undermine trust, as can top-down practices and short-term goals, poor information, and a lack of communication (Milbourne, 2013). Vangen and Huxham (2003a) suggest that it can take several years for aspects of trust to reach a ‘comfortable level’ in collaborations.

Trust in collaborative contexts is therefore an interplay between the systems and structures of collaboration and the individuals within it. The role of individuals is particularly important both in the sense that they can work to initiate and sustain trust (Milbourne and Cushman, 2013) and that they can embody wider aspects of trust in systems and institutions (Bachmann, 2001). Milbourne and Cushman (2013) in particular point to the role that key individuals have in developing trust, primarily through communication across organisational and institutional boundaries between the voluntary and public sectors. This trust did not continue once they were removed, suggesting that trust was not embedded in the wider system. The reliance of this research on interview data is somewhat problematic as regards uncovering what actually happened in practice; it may be that trusting ways of working continued despite this perceived issue.
The interplay between personal and system trust is particularly important for this research as Bachmann (2001) suggests that there can be different traditions of working related to these two aspects. On the one hand contexts with a high level of personal trust will also have high levels of personal power. Consequently, autonomy will be high, and individuals will be able to make decisions and effect change directly. In contexts with high levels of system trust and power, individuals merely represent the system in which they work and as a result have very low levels of autonomy. The latter is more likely in environments with strong hierarchies and structured ways of working, such as in the NHS. As we saw above, such structuring aspects can help to increase trust by decreasing risk and Bachmann (2001) suggests high levels of system trust can ‘supercharge’ trust across different organisations and individuals. However, such environments lack the flexibility to deal easily with change. In contrast, environments with high levels of personal trust can be more flexible and innovative but fall apart if key individuals leave. Although Bachmann compares traditions of trust in different countries it is possible that there are different traditions across sectors within countries, such as between public and voluntary sectors in the UK. Milbourne and Cushman (2013) point out that the introduction of NPM and NPG ideals within voluntary-public sector relations has led to a decline in autonomy and personal trust and that this in turn has led to an increase in hierarchical aspects of control. They also suggest that the decline in funding seen during austerity potentially has the impact of decreasing trust, precisely when it is needed the most as the voluntary sector is expected to deliver ‘more with less’ either through squeezed budgets or through free services as a ‘safety net’. They suggest that this results in "a conspiracy of over-optimistic reporting to manage the reputational and financial risks associated with unrealistic performance expectations in extremely challenging services." (p.504). This link with reporting is important as it creates pressure through policy in which service providers cannot be seen to fail. This can result in ‘massaging’ information or ‘gaming’ the statistics of collaborative partnerships in order to show success (Milbourne, 2013). Voluntary sector organisations, as they have come to rely on public money, can quite feasibly act as collaborators in maintaining this conspiracy. In addition, the lack of resources and capacity in
austerity contexts may mean that the public sector are less inclined to consult widely with the voluntary sector and rely on a small number of organisations or individuals to carry out the engagement processes mandated in NPG ideals. This may actually be necessary in order to protect smaller organisations - who benefit from higher levels of trust with communities but lower levels of public funding – from the negative isomorphic pressures that greater engagement with the public sector can bring. Trust is vital for participatory processes, and public sector workers and policy makers are aware of this. The question then becomes whether the emphasis we see on trust in policy is a true commitment to the process of initiating and nurturing trust or whether it is seen as an instrumental goal in itself and something that can simply be achieved and then forgotten about. This is important as trust is presented as a solution to many of the issues of managerialism. If the concept itself is able to be subsumed within NPM and neoliberal policies, then emphasising trust in policy will only seek to embed these issues further. Billis (1993; also, Billis and Glennerster, 1998) points out how other sectors attempt to ‘steal the voluntary sector’s clothes’ – to take their ‘comparative advantage’ – by adopting elements associated with the sector. As important as trust appears to be within voluntary-public sector relationships, the dynamics of the two sectors working together, and the influence of management ideals, mean that at times trust can act as a façade for power or as a masquerade hiding manipulation – in which dominant actors dictate meanings and narrative – and capitulation – in which subordinate actors surrender to dominant arrangements (Milbourne, 2013). As a result, it is also necessary to consider how power works in these contexts.

3.3.2 Power

Power is another subject with a vast and varied history in the academic literature. Sadan (2004) building on Clegg (1989) provides an overview of competing theories of power from Machiavelli to Anthony Giddens, through Gaventa and Foucault. Key insights from this literature that are relevant to collaborative contexts include the notion from both Foucault and Giddens that power is a central
component of social life and that it is exercised rather than held. This has important implications in relation to agency, and Sadan (2004) takes up Giddens’s Structuration Theory to highlight the importance of both structure and agency. Giddens suggests that each individual possesses knowledge and consciousness and is able to exercise those elements in practice. However, power is not entirely equated with the ability to use it – although the notion of ‘capacity’ in power is important to distinguish it from influence – as power is dispositional and doesn’t have to be activated in order to have significant effects (Lukes, 2015). Additionally, power doesn’t have to be intentional or felt by those with power – you can have power over someone or something without knowing it even exists (Lukes, 2015). Power acts both on those with and without power and in a ‘three dimensional’ way (Lukes, 1974 in Sadan, 2004). This approach acknowledges the overt (first) dimension of power – A’s power over B to do something they wouldn’t have otherwise - which can be identified through behaviour, and the covert (second) dimension which considers who has a say in what, when and how issues are discussed and who remains outside of decision-making. It also acknowledges a latent (third) dimension which suggests that social and historical factors shape the expectations of both the powerful and powerless and impact on the ability of the powerless to both identify their situation and act upon it. In addition, power is not an absolute or one-sided concept, just because it is entrusted to someone it doesn’t mean it is absent from others. Follett (1925) provides an important insight into this in relation to group or organisational settings in that instead of the notion of ‘sharing’ a finite amount of power the focus is on creating additional power for those less powerful. The advantage of this is that no one is forced to ‘give up’ power which avoids potential tensions in inter-personal or inter-organisational settings. Follett equates this conception with the development of a notion of ‘power-with’ instead of ‘power-over’: “a jointly developed power, a co-active, not a coercive power.” (Follett, 1925, p.103). The concept of ‘equal power’ implies conflict over a set value of power, whereas ‘power-with’ implies cooperation and a jointly developing power, unifying while allowing for difference. If we accept this conception of power, within collaborative settings additional power can be acquired without diluting the power of other stakeholders. Power can develop through the
collaborative work itself - “the blossoming of experience” (Follett, 1925, p.113-4) - rather than through any notion of ‘sharing’.

In voluntary-public sector relations, much of the literature suggests the voluntary sector enjoys less power than public sector organisations, even in collaborative arrangements (Osborne, 2000; Milbourne and Cushman, 2015; Taylor et al., 2016), particularly in the current climate of austerity that has impacted on the voluntary sector’s critical voice (Hemmings, 2017). However, the voluntary sector is not one homogenous mass and different organisations have different levels of power (Alcock, 2010). In addition, an organisational drive focussed solely on developing more power may in turn weaken the distinctive identity and ethos of the sector (Rochester, 2013). Many of the concerns about power in the voluntary sector relate to resources - including who provides funding or ‘holds the purse strings’ in any collaboration with the public sector - and the unsatisfactory experiences of such relationships from a voluntary sector point of view (Taylor, 2001). However, often perceptions of power dynamics do not match the reality (Huxham and Vangen, 1996) and engaging in collaborative working with other organisations implies that the ‘more powerful’ organisation needs something that the ‘less powerful’ organisation has. Bouchard and Raufflet (2019) have explored this resource power in collaborations between non-profit organisations and private businesses. They suggest there are four aspects of resource that can play a role:

1) Funding – who provides the money
2) Learning – how much knowledge organisations have in how to collaborate
3) Networking – what ties organisations have within and across sectors; and
4) Branding – who is able to take the credit for success and claim ownership.

They state that some voluntary sector organisations are able to exert power in collaborative environments by leveraging these different elements. However, their research took place within a Canadian context and mainly looks at the role of international Non-Governmental Organisations (NGOs); it also relies on survey and semi-structured interview data and so is limited in its insight into
practice. Nevertheless, their research suggests power is not as straightforward as simply being in the hands of those who fund a collaboration.

Collaborations themselves can threaten current distributions of power and as a result the management of them is a key concern (McCann and Gray, 1986). In the collaboration literature, Huxham and Beech (2008) provide an overview of how power manifests in collaborative settings, working with the definition that power is “the ability to influence, control or resist the activities of others” (p.556). They suggest power can be treated in three different ways within collaborations – the need for organisations to control their relationships with others (‘power over’); the power to achieve ends more effectively through joint action (‘power to’); and, the successful ‘empowerment’ of less powerful groups (‘power for’) (see Figure 3.1 below – p.77).

**Figure 3.1 - Presumptions of Power in Collaborations**

<table>
<thead>
<tr>
<th>Concerns directed at the benefit of the whole</th>
<th>Concerns directed at sharing power</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>POWER OVER</strong></td>
<td><strong>POWER TO</strong></td>
</tr>
<tr>
<td>A focus on control</td>
<td>A focus on joint outcomes</td>
</tr>
</tbody>
</table>

(Source: Adapted from Huxham and Beech, 2008, p.560)

Power in collaborative contexts is concerned with the programme, processes and outcomes of inter-organisational entities, in the sense that all stakeholders within a collaboration need power “in order to have access to, and influence, agreements about joint objectives and the way in which these are actually carried out.” (Huxham and Beech, 2008, p. 559). While acknowledging equality of power can’t be expected, Kähkönen (2014) suggests that collaborations work more easily when there are no major disparities of power between stakeholders. They also note that actors in dominant positions may be reluctant to collaborate and risk giving up their position. The power to convene is of particular importance in collaborations, coming as it does with the power to set parameters, processes and
decision making (Gray, 1989; Lotia, 2004). Conveners also tend to have power over when a collaboration ends. It is important to highlight that consensus in relation to any of these factors does not necessary mean that power isn’t being exercised, Lukes’ notion of the ‘third-dimension’ as described above implies that “those situations which may appear to be free from the exercise of power can be those in which power differences are the most deeply ingrained” (Lister, 2000, p. 230).

Lotia (2004) identifies the following sources of power in collaborations:

- Resource power – related to funding, capacity, time etc.
- Image/prestige power - based on how an organisation is perceived or how its work is recognised
- Expert power - from experience, competence etc.
- Connections power - Links with other organisations and individuals

Similarly, Huxham and Beech (2008) distinguish different sources based on macro and micro levels (see Figure 3.2 below – p.79):

MACRO:

- Power based on need imbalance – i.e. what organisations need from the collaboration in order to participate – skills, information, funding.
- Power based on importance imbalance – e.g. strategic centrality, uniqueness, access to sanctions – how much an organisation is needed by others and/or the collaboration as a whole. The threat of pulling out can be very powerful.
- Power based on structural position – formal authority, network centrality etc. – they suggest collaborations don’t tend to have a formal hierarchy and as a result designation can be very powerful, such as who is named as the official ‘lead’ organisation. Having strong connections with other organisations plays into this.
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MICRO:

- Power based on day-to-day activities – points of power inherent in the relationship process – this can occur in potentially infinite ways through micro-politics and “the ability of actors to change the power relationship between themselves” (Huxham and Beech, 2008, p. 567).

**Figure 3.2 - Sources of Power in Collaborations**

<table>
<thead>
<tr>
<th>Macro-Level</th>
<th>Micro-Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Power based on need imbalance</td>
<td>Power based on day-to-day activities and relationships</td>
</tr>
<tr>
<td>Power based on importance imbalance</td>
<td>Power based on structural position</td>
</tr>
</tbody>
</table>

(Source: Adapted from Huxham and Beech, 2008, p.563)

Lister (2000) suggests that collaborative relationships fundamentally rely on individuals rather than institutions and so the micro-level of power dynamics may be more vital in practice than macro elements. This way of viewing micro-power sees every point of action by individuals as a potential source of power. Therefore, any individual or organisational stakeholder that is able to take action is able to have power. Micro-power can influence or counteract macro-power and vice-versa and different types of power become more or less relevant over the lifetime of any collaboration. The ‘power batons’ will similarly shift between individuals and organisations. For the voluntary sector, the micro-power aspects of ‘expertise’ and ‘connections’ would appear to offer areas to exert power, based on the assumption that the sector is better connected to, and knowledgeable about, communities and individual citizens.

Bachman (2001) details the relationship between ‘personal’ and ‘system’ power, in the same way that differences in trust interact. This will be discussed further in the section on the interactions of Trust, Power, and Control below. Power can be a precursor to trust (Bachmann, 2001) and trust can act as a counterforce for power (Kähkönen, 2014). Crucially, trust and power are both functions and mechanisms of control (Huxham and Beech, 2008; Ran and Qi, 2018).
3.3.3 Control

Control in this context refers to the direct ability to make decisions about aspects of voluntary-public sector working. Notably this includes control over resources which Ran and Qi (2018) suggest is directly related to having power. Other aspects of control include control of information, and control of the narrative around a project – whether it is framed as worthwhile and what aspects of it are suggested as having been successful. Trust can act as a ‘soft’ control mechanism to manage different aspects of collaborative working (Ran and Qi, 2018). Socially oriented collaborative efforts often have to rely on such softer control mechanisms as setting up contractual relationships is not generally a feasible option (Vangen and Huxham, 2003a). Voluntary sector organisations who engage in cross-sector working also risk giving up control of their work to the collaboration itself, particularly if the issues they work on become ‘mainstreamed’. This in turn can threaten the very existence of those organisations (Vangen and Huxham, 2003a). Loss of control to the collaboration is a result of lower levels of power and a lack of trust in the collaborative process. This creates pressure on voluntary sector organisations to accept the – top-down - ways of working of collaborations that they have very little control over. In particular, this includes the maxim of ‘do more with less’ (Himmelman, 2001), acting as a ‘rationalization’ (Flyvbjerg, 1998a) for the ideological actions of the powerful. This pressure results in people and organisations being over-extended and over-promising, leading to stress, lack of follow-up and growing incompetence (Himmelman, 2001). In contrast, collaborations that begin with communities and only invite larger institutional involvement after relationships have been agreed – that develop with bottom-up control – mean that people and the communities that they are in become “subjects of their own purposes” (Himmelman, 2001, p.282) and are empowered to take a role in representing their own lives and engaging with solutions to social problems. Nelson (2017) suggests Follett’s ‘Direct Social Democracy’ also supports this as it emphasises bottom-up (community) control and focusses on expanding citizens’ ability to act and organise. That, in turn, encourages self-regulation and societal regeneration. This is not to say there is a strict dichotomy between top-down (state) and bottom-up (community) control, or that the voluntary sector or
community act as an alternative to state provision, but rather that they are both partners in tackling social problems (Taylor, 2002).

3.3.4 Interactions of Trust, Power, and Control in Collaborative Contexts

I have reviewed extant research which highlights the importance of both trust and power in voluntary-public sector relationships, but these two aspects also interact to influence how control works in collaborative relationships where traditional hierarchical and contractual ways of working become blurred (Bachmann, 2001). Ran and Qi (2018) note that control is a function shared by power and trust and that control over aspects of collaborative working such as resources and narrative can impact on power. Milbourne and Cushman (2011) note that arrangements that can codify power such as contractual relationships or specific goal/outcome agreements are generally not feasible in socially oriented collaborations between the voluntary and public sectors. As such, these ways of working have to focus on ‘softer’ control mechanisms in order to manage power relations. Equally, Vangen and Huxham (2003a) note that although goal agreement in collaborative settings may be a way of building trust it is not often achievable and as a result just getting on with some practical work (within the context of some general aims) is a necessary first step. This in turn can alter power dynamics in relation to which organisations are able to work quickly and pragmatically – a characteristic historically attributed to the voluntary sector (Knapp et al., 1990; Munro, 2018).

Bachmann (2001) suggests that trust and power operate on the same principle in that they both aim to influence actions in the face of alternatives and that “most social relationships are based on a mixture of both trust and power” (p.351). However, trust implies hope that any ‘other’ will act in the ways expected whereas power threatens sanctions if the ‘other’ displays undesirable behaviour. Trust works on positive assumptions while power is based on a “negative hypothetical possibility” (Bachman, 2001, p. 350). Power relies on the threat of any sanction being likely to occur. As a result, much like trust can be ‘betrayed’, power can break down if not actioned. However, Bachman (2001) argues that this is not likely to be as damaging as when trust is lost.
The characterisation of power as the ‘bad’ to the ‘good’ of trust highlights the reputational problem that power has in that it’s usually seen as an unacceptable form of control. However, Bachman (2001), drawing on Foucault and Habermas, suggests that power can be viewed as purely a means to coordinate, rather than dominate, and to both confirm and challenge authority. In some ways this relates back to conceptualisations of agency in debates about power, which are also either positive – we as humans have agency – or negative – we don’t. In practice it is likely that all partners will have ‘some’ agency and therefore ‘some’ power. The voluntary sector is often painted as the victim of or ‘subordinate’ to the public sector (Milbourne et al., 2003) but the organisations within it do have significant agency to comply or resist any aspects of power. They are not simply victims and often take the choice to be involved in certain ways (6 and Leat, 1997; Rees et al., 2012). As collaborative relationships are based on a mixture of power and trust both are also limited in their capacity to control relations. Using them both, in interaction, is therefore likely to be the way to achieve individual, organisational, and collaborative goals however one is likely to dominate over the other (Bachman, 2001). We can see this sort of interaction in the collaboration literature with Vangen and Huxham’s (2003b) notion of ‘collaborative thuggery’ or Jacklin-Jarvis’s (2014) ‘collaborative disruption’ which both, while expressed in negative language, hint at the positive role power can play in achieving the goals of the collaboration itself (thuggery) and the goals of organisations and individuals within it (disruption). Milbourne and Cushman (2013) suggest that in the current UK austerity context, power relations are likely to dominate but that they may masquerade as trust in order to generate legitimacy. This masquerade is sustained through the control of discourse within voluntary-public sector working. In relation to the emphasis on co-production and community engagement that we have seen typifies New Public Governance approaches to delivery – and which have been emphasised in the austerity context – the notion of ‘bottom-up’ (i.e. from communities upwards through delivery systems) control is emphasised in contrast to ‘top-down’ (authoritative, bureaucratic processes) ways of working. However, with the drive towards ‘bottom-up’ approaches part of government policy, and with public sector organisations tasked with implementing this, the
power to define how this works in practice is likely to remain with the public sector. Taylor (2001) noted before the 2008 financial crisis which led to political austerity in the UK that the voluntary sector did not have the power to set the ‘rules of play’ for interactions with the public sector or have the power to make as many ‘moves’ within the play itself. Furthermore, the right of the sector to even play at all was questioned. Milbourne (2009; 2013) writing after the financial crisis, noted that the voluntary sector remained ‘junior partners’.

To return to Bachman (2001), they suggest that a choice between power and trust only really exists in environments with low system and high personal trust. This is because if risk is high, trust is unlikely to be the preferred option and so power will dominate both over others and onto actors from others. So, in systems with low institutional regulation – and therefore low system trust – power is likely to be the dominant mechanism (in this case, personal power to go along with personal trust), whereas if system trust is high – where there are collective norms or standards of trusting behaviour – then (system) trust is more likely to dominate over (personal) power. However, power isn’t absent from these environments it’s simply invested in system power – rules, hierarchy, technical guidelines etc. This system power can itself ‘mass-produce’ trust and hence can be seen as a precondition of trust rather than an alternative.

Systems are too complex to be dominated by personal trust alone, but a lack of collectively binding norms and standards can lead to a reliance on personal trust and therefore personal power. Interactions in such settings are then less likely to be based on trust. This supports the importance of previous good experiences of collaboration between organisations as that will encourage shared ways of working, system trust, and therefore system power. This will in turn facilitate trust development and maintenance. This system power itself would more than likely have been originally built by (personal) trust however, or power doing the job of trust through organising via personal power. As noted previously, this isn’t a bad/good dichotomy, as the different elements allow for different ways of working, which Bachman (2001) calls ‘patterns of social control’. The implication here is that voluntary sector and NHS participants in collaborations will require different approaches to getting
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the most out of their working relationships because of their different starting points. Both Bachmann (2001) and Ran and Qi’s (2018) papers are theoretical and there is a lack of empirical evidence exploring these issues in practice.

3.3.5 Summary of Trust, Power, and Control in Voluntary-Public Sector Working

In summary, trust, power, and control appear to be interlinked aspects of inter-organisational working, particularly when organisations with very different traditions come together. However, much of the literature that explores this is theoretical and lacks empirical evidence of how these interactions play out in practice.

There is often a gap in relation to what is meant by ‘trust’ as a term in the voluntary sector literature but a general assumption that it is a fundamental element of the sector’s existence. A notable exception to this is the work of Milbourne and Cushman (2013; also, Milbourne, 2013) that explores aspects of trust within the sector and the role that closer working relationships with the public sector can play in reducing trust both in the sector itself and in service delivery. However, often there is an implication within such research that trust is always a positive thing, and little acknowledgement of the potential downsides of trust. This is echoed in recent policy and ‘grey’ literature (NHS, 2016i; Collaborate, 2017; Civil Society Futures, 2018). Collaborative working does offer the potential to nurture relationships through ‘loops’ of trust building (Vangen and Huxham, 2003a) but this is difficult and may take years to embed in successful working practices. Power in collaborative settings emphasises the role of ‘power-with’ participants and links closely with ideals of co-production and community engagement.

Much of the voluntary sector literature sees the sector as having less power than its public sector partners, mainly related to the power of resources, funding in particular. The role of public sector organisations as ‘conveners’ of cross-sector working also suggests they will maintain a wide range of power in relation to setting the goals and ways of working of any approach. However, aspects of micro power in collaborative settings means that the voluntary sector may enjoy some power in
relation to their expertise in working with communities and their links across organisational and community boundaries, in addition to leveraging aspects of resource power as described by Bouchard and Raufflet (2019). The emphasis on co-production links with attempts to devolve or localise control in communities and act in a ‘bottom-up’ way to develop and deliver better public services. However, this can also act as a rationalization for cuts to services under austerity. Austerity can also increase the likelihood that what appears to be trust is acting as a masquerade for power.

Bachmann’s (2001) approach suggests that contrasting environments can exist for personal/system trust and power, with different traditions resulting in different ways of working. This is not to say one is normatively better than the other but that when there are attempts by organisations to work together these different traditions may clash, making success difficult to achieve. Although Bachman’s (2001) work contrasts national contexts it can potentially be applied to cross-sector working.

A common theme within the data collected for this research was the role of leadership in driving successful voluntary-public sector working, as Chapter 6 – Findings, will show. The next section of this Literature Review will consider the approaches to leadership that are likely to play out within voluntary-public sector collaborations.

3.4 Leadership

Leadership is a “maddening concept” (Alvesson, 2017) and leadership studies is a highly complex field in which even the definition of the term itself is unclear. Grint (2010b) suggests that:

"despite almost three thousand years of ponderings and over a century of ‘academic’ research into leadership, we appear to be no nearer a consensus as to its basic meaning, let alone whether it can be taught, or its effects measured and predicted." (p.2)

As a result of this complexity, it is difficult to begin to explore the subject without establishing some parameters. Firstly, I have chosen not to focus on the Leadership Studies field or on leadership as a general subject. Others have provided excellent overviews of this literature and the various traditions within it (see Grint, 1997; 2010b; Jackson and Parry, 2011; Zaccaro, 2014; Alvesson and Spicer, 2014).
Instead I will focus firstly on the literature regarding leadership in the voluntary sector specifically; secondly, I will introduce insights from the collaboration literature around the need for different aspects or types of leadership in collaborative settings; thirdly I will also detail how concepts such as ‘shared’, ‘distributed’, and ‘relational’ leadership that exist in the general leadership literature can be useful in predicting how leadership will work in this context, particularly in light of policy documents that call for greater community involvement in service delivery, co-production of services, and network approaches.

3.4.1 Leadership in the Voluntary Sector

Research into leadership in the UK voluntary sector is relatively limited (Macmillan and McLaren, 2012; Howieson and Hodges, 2014; Hodges and Howieson, 2017; Munro, 2018; Terry et al., 2018; 2019). However, there has been a general suggestion that there is something different about leadership in the sector, particularly when compared to the public and private sectors. Howieson and Hodges (2014) describe this as ‘common sense’ based on the fact that voluntary sector organisations face a ‘triple bottom line’ of financial, social and environmental factors – that other sectors do not – and that the motivation of sector organisations is towards difficult or ‘wicked’ problems, which contrasts with the private sector motivation for easy answers. Much of the recent literature focuses on leadership ‘of’ the voluntary sector, rather than leadership ‘in’ it (see Macmillan and McLaren, 2012; Buckingham et al., 2014) and this is reflected in the grey literature about the subject that focuses on the need for leadership in order to promote a sector ‘voice’ or to have a place at the table in policy and service delivery (Independence Panel, 2015; Cabinet Office, 2018). This conforms to the notion that there is a coherent voluntary sector that can strategically be promoted and ‘led’, particularly in its relationships with ‘other’ sectors. This is despite repeated suggestions that the heterogeneity of the voluntary sector means this is not an accurate picture in practice (Alcock, 2010; Alcock and Kendall, 2010; Rees and Mullins, 2016b). Leadership development programmes in the sector tend to focus on individuals who are already in senior, hierarchical positions (Clore, 2017;
NCVO, 2017; King’s Fund, 2017b) which gives an impression of leadership as something particularly ‘high-level’. Although ‘The Centre for Voluntary Sector Leadership’ is a notable exception (CVSL, 2020). All of this literature supports the dominant narrative that there is a ‘leadership deficit’ in the sector (Kirchner, 2006; Jacklin-Jarvis et al., 2018) which itself refers back to ongoing attempts to ‘professionalise’ the sector which have been a central drive of New Public Management and New Public Governance reforms. In addition, the continued notion of a ‘sector’ leads to ideological and politicized views about leadership that have emphasised the need for greater managerialism and its related approaches (Goh, 2017). This is in contrast to the idea that leadership in the voluntary sector is traditionally ‘values based’ reflecting the general idea of the sector as being driven by a moral obligation to ‘mission’ and to employee and user involvement (Howieson and Hodges, 2014).

Managerial approaches are therefore seen as not suitable (Rochester, 2013). The impact of austerity has meant that ‘leaders’ in the sector have increasingly seen their role as ensuring organisational survival in the context of increasing competition between organisations, making a coherent ‘sector’ approach less likely (Macmillan and McLaren, 2012). However, as noted previously, austerity has also forced organisations to look at more collaborative ways of working in order to survive (Hodges and Howieson, 2017). The two aspects of survival and collaborative working, in combination with the commitment to values and ‘mission’ leads to what Howieson and Hodges (2014) term ‘triple-strength leadership’ that operates in a ‘tri-sector’ context across public, private, and voluntary sectors. Leaders therefore need to act in ‘collaborative’ ways that: allow deliberation; encourage critical thinking; that are flexible, inclusive and empowering for others; that manage complexity; and that emphasise sustainability, quality, and innovation in service delivery. This sees collaboration as a form of leadership itself but one that is expressed as a leadership skill that individuals need to display in order to successfully lead their organisations, and the wider sector as a whole. This reflects much of the literature that looks at leadership ‘in’ the sector in that it is mainly focussed on person-centred or skills-based approaches (Terry et al., 2018; 2019). Although Hodges and Howieson’s work (2017; also, Howieson and Hodges, 2014) is useful in providing insights into
what leadership may be in the voluntary sector – and is one of few empirical studies that aims to do so – it is limited in that it is based on the personal narratives of pre-identified ‘leaders’. As a result, whether these personal perceptions play out in practice or not is an unanswered question. In addition, much of the previous research emphasises the positives of collaborative leadership without acknowledging the potential downsides. This reflects the same emphasis in the general leadership literature (Alvesson, 2017).

Despite the dominant focus on person-centred approaches to leadership in the sector, some academic work does focus on leadership in broader terms as "a multi-dimensional, sense-making, socio-political, cultural and enactment process" (Kay, 1996, p.131). In this conceptualisation, leadership in voluntary sector organisations has four dimensions that contain paradoxical elements in that they can all overlap at the same time and in the way ‘the leader’ both creates and discovers their reality:

1) **Leadership as a social and cognitive sense-making process** – bringing together multiple perspectives, interests, and explanations in order to make sense of experience.

2) **Leadership as a socio-political process** – creating and influencing commitment to particular perspectives, searching for socially acceptable meaning, both about change (moving forward) and stability (core organisational values).

3) **Leadership as a cultural process** – both attempting to integrate and create harmony/homogeneity and allowing for multiplicity of meaning through fragmentation.

4) **Leadership as enactment** – actions reflecting socially accepted meanings – including the vetting of actions to check conformity with what is currently acceptable.

For Kay (1996), the paradox of diversity/unity is the key aspect at the heart of leadership in the voluntary sector. The four elements provide opportunities for different people, at different organisational levels to enact leadership. However, although Kay’s approach opens up leadership beyond those ‘at the top’ it still suggests there are specific leadership skills that individuals need to
develop and that those at the top of organisations are likely to have considerably more influence than those at the bottom. This implied hierarchy is perhaps not surprising as Kay’s research was based on interview data gathered from participants in senior positions and is carried out with an interpretivist lens. As such, although it hints at inter-subjective meaning-making it is not able to entirely embrace it, suggesting instead that ‘the leader’ (individually) both creates and discovers their reality. A research approach that focuses on action rather than participants’ ‘espoused theories’ (Argyris and Schön, 1974) would be more able to identify whether this is what actually happens in practice. Nevertheless, the opening up of leadership in the voluntary sector away from hierarchical or ‘heroic’ models that Kay encourages, can be seen in the adoption of a more relational approach in both a UK (Macmillan and McLaren, 2012) and USA (Ospina and Foldy, 2015) context. This also reflects movements in wider leadership literature (Howieson and Hodges, 2014; also see Grint, 2010a; 2010b; Cunliffe and Eriksen, 2011; Alvesson and Spicer, 2014; Ospina and Foldy, 2015; Bolden, 2016).

3.4.1.1 Community Leadership

An element of the voluntary sector that has significance in relation to how leadership is enacted in light of a move away from hierarchical aspects of leadership is the role of service users and community members under the banner of co-production. Chapter 2 – Context, and Section 3.2 of this literature review have highlighted the emphasis on community engagement and representation in public sector policy and the tension that this can create within voluntary sector organisations. Alongside this we have seen a greater emphasis on ‘place’ leadership – leadership of geographic communities (Hambleton and Howard, 2013; Hambleton, 2015) - in which the voluntary sector is seen as playing a vital role. This raises questions of legitimacy that are unanswered in current voluntary sector literature in relation to leadership. It may be that particular ‘local heroes’ or social entrepreneurs are able to enact leadership because of the overall emphasis on the need to engage with ‘the community’ but lack wider legitimacy within those communities. This again focuses on the role of individuals in leadership, and for voluntary sector organisations risks undermining their ability
to enact leadership based on a removal of their representative advocacy role, as referenced in Section 3.2.6. This is likely to be a particular issue for smaller organisations in the sector who may lack the capacity and resources to enact either their own leadership role or enable the leadership role of their members/users or the wider communities that they represent. The ‘scattergun’ approach to leadership in the sector (Howieson and Hodges, 2014) could create a vacuum that is filled not by voluntary sector organisations but by individual community members. This hints at what Sutherland et al. (2014) suggest is ‘anti-leadership’. Anti-leadership begins from the position that leadership is “an alienating social myth” (p. 762) and - that even if acknowledged as such - is reproduced within any organisation that either contains formal hierarchy or rejects formal hierarchy without acknowledging informal hierarchies that are rooted in power relations. A failure to acknowledge imbalances, even in supposedly democratic organisations, can lead to the congealing of leadership into formal structures or cliques of individuals, particularly as wider societal norms around gender, race, sexuality, age etc. can be reproduced. A strength of Sutherland et al.’s (2014) work is its ethnographic focus, which although relying heavily on interviews does attempt to observe the practice of participants. It focuses on social movement organisations so whether this applies to the voluntary sector more generally is unknown.

In relation to engagement with other organisations and sectors, representatives removed from their community to act as leaders can become detached from the very issues they seek to represent (Barr and Huxham, 1996; Taylor, 2002). As smaller, community-based groups struggle to enact leadership, the role of infrastructure organisations becomes particularly important in relation to their ability to act as a voice for the sector. Notably, as detailed in Section 3.2.6, infrastructure organisations confront the issue of unity/diversity in their very existence and so are perfectly positioned to balance the tensions of leadership that Kay (1996) describes. Unfortunately, although Macmillan (2016) identifies three fundamental roles that infrastructure can play in ‘influencing’, ‘developing’, and ‘connecting’ the sector, Donahue (2011) has suggested infrastructure organisations are failing micro organisations – the very organisations that would benefit from this support to enact leadership at a
local level. Although Donahue’s research lacks robustness, being as it is merely a reflection on their personal experience in the sector, it is supported by Mohan (2012) as regards the limited engagement infrastructure organisations have with the wider voluntary sector. Although local organisations have been shown to report very positive experiences of infrastructure support, the risk of a ‘self-perpetuating elite’ where the same groups are involved time and time again has been noted (Osborne et al., 2006). In relation to leadership, this elite would hold a particularly strong position in terms of both their role within the sector and their representation of the sector with partners, including the public sector.

3.4.1.2 Summary of Leadership in the Voluntary Sector

To summarise, leadership in the voluntary sector is a mix of approaches, that reflect some of the developments in leadership studies more generally. Although there have been attempts to open up the concept to include actors at all levels of organisations and communities there is still an emphasis on the need for those in formal positions of leadership to develop the skills to ‘lead better’. Although it may be ‘common sense’ that leadership is different in the sector, the lack of research that focuses on the subject, coupled with the ‘mythical’ nature of a lot of the assumptions made about the way that the voluntary sector works means that further, empirical research is necessary in order to both interrogate those assumptions and to provide a more detailed understanding of leadership.

This thesis is focused on a voluntary sector-NHS collaboration and so it is important to identify the leadership role the sector has been able to play in such contexts. The next section will consider this.

3.4.2 Voluntary Sector Leadership with the NHS

As much as there is a ‘relative paucity’ (Howieson and Hodges, 2014) of research into voluntary sector leadership in the UK, the literature that focuses on the leadership role the sector can play in collaborations with the NHS is even more limited. What little there is focuses on leadership in relation to innovation (Newbigging et al., 2017) and/or the role of ‘community leadership’ (Gillard et al., 2014)
via co-production for service improvement (Windrum, 2014). The voluntary sector is assumed to enable community involvement, but the ‘leadership’ role is seen as coming from the community itself rather than the sector (Gillard et al., 2014). Newbigging et al., (2017) suggest that the voluntary sector is able to provide leadership in NHS settings, particularly through peer support and non-medical response models, notably in meeting the needs of ethnic minority communities. The authors do not define what they mean by leadership in this context however they do draw attention to the ‘relational-based’ approaches of the sector, in comparison to the “inflexible, risk averse and biomedical approach of statutory services” (p.1). Windrum (2014) also notes that the voluntary sector can play a “key role” (p.1053) in the leadership of health innovation through both shaping new services and through acting as ‘honest brokers’ between patients and public sector health providers. Interestingly, Windrum’s research included four case studies across different countries, all of which were initiated by voluntary sector organisations who also acted as the ‘lead partner’. Further research is needed to establish whether initiating or ‘convening’ collaborations leads to a greater leadership role for the sector. The collaboration literature discussed in Section 3.3.2 suggests that it would. Certainly, within Wellbeing Erewash, the NHS were both conveners and lead partners.

3.4.3 Leadership Within the NHS

Although research into leadership in voluntary sector-NHS relations is sparse, there has been a large amount of research into leadership within the NHS generally. The NHS is one of the largest organisations in the world and as a result it is very difficult to make broad generalisations about it. However, recent years have witnessed high profile incidents within the NHS that have been conceptualised as failures of leadership at multiple levels, linked to negative aspects of organisational culture (Dixon-Woods et al., 2013). Policy responses to these failings have focussed on ‘system’ approaches (King’s Fund, 2017c; Ham, 2018) and a desire to enact ‘transformational change’ through ‘shared’ and ‘distributed’ leadership (Hunter et al., 2015; Martin et al., 2015). However, as much as these ‘collective’ responses have been framed as necessary to combat failures they are also linked to
a continuation of New Public Governance ideals around collaborative approaches to public service delivery (Ospina, 2016) and to an overarching austerity politics focussed on cutting public service expenditure. Borrowing approaches from the private sector, this emphasises engaging individuals at all levels of the organisation, conceptualising the NHS as a ‘network’ (Malby et al., 2013), whilst also acknowledging that some individuals are likely to be more key than others (Hunter et al., 2015).

Network leadership within the NHS is seen as having to be flexible, distributed, democratic and inclusive; connect and empower members; delegate responsibility; and focus on impact (Malby et al., 2013, p.56). In addition, environmental factors that impact on the NHS, such as political and economic change, enact a strong leadership effect on the organisations and its partners (Hunter et al., 2015). This focus on the role of individuals within a wider system is aimed at encouraging two specific approaches to leadership as both enabling others to achieve in the face of uncertainty – ‘guardianship’ – and to encourage behaviours that depart from accepted norms and enact change - ‘positive deviancy’ (Coleman et al., 2013). These behaviours and skills of leadership have been supported and developed by the NHS Leadership Academy, which delivers training to NHS employees. Such leadership training formed part of the context in which Wellbeing Erewash operated as Chapter 6 -Findings.

The notion of ‘distributed leadership’ (DL) has been adopted as a key strand of NHS policy and focuses on engaging and empowering, “so that there is a vertical flow of power from the centre downwards, and perhaps even beyond the boundaries of the organization” (Martin et al., 2015, p.15).

These ideas build on Gronn’s (2002) work on DL, which itself included a large emphasis on collaborative working within organisations. The idea behind DL in a health context is that all people across the organisation, no matter where they sit in any hierarchy have ‘voice’ and the ability to make decisions relevant to their field of work. Although these developments hint at a widening concept of leadership, much of the literature only considers this ‘sharing’ to be within the NHS itself rather than with other organisations. In addition, within the NHS, leadership is mainly seen in the literature as the domain of clinical professionals (see Ham, 2003; Malby et al., 2013). This notion is hardwired into
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recent NHS reforms with the establishment of ‘Clinical Commissioning Groups’ (CCGs) in 2012 and can be seen in promotion of the concept of ‘compassionate leadership’ in the grey literature – the idea that clinicians should show compassion in the way they deal with patients (King’s Fund, 2017a) and that this is the key leadership interface the NHS has. This is particularly important in relation to Wellbeing Erewash as for the most part the voluntary sector’s main contacts in the NHS were managerial and administrative staff members who would not seem to have a place in this conception of leadership. It is not clear therefore how interfacing with the NHS through non-clinical staff can lead to leadership opportunities. Further to these issues, leadership is still very much a ‘top-down’ burden within the NHS (Anandaciva et al., 2018) with a “near toxic mix of pressures” (p.7) giving rise to many vacancies at more senior levels within the organisation (Kerr, 2018; Anandaciva et al., 2018). Leaders also still report feeling a high pressure to ‘lead’ as individuals and a lack of support to do this, coupled with increased pressure ‘from above’ (central government and NHS England) to carry out monitoring requirements for services (Kerr, 2018). This suggests a continuation of New Public Management ideals, as detailed in Section 3.2.2. A distribution of responsibility towards others both within the organisation and to partners would seem to be a positive step in addressing these issues but even recent approaches that claim to be working in this way have fallen short, as seen in the development of ‘Sustainability and Transformation Plans’ (Alderwick et al., 2016). There is also a lack of empirical evidence that shared or distributed leadership approaches can be sustained over the longer term (Jackson and Parry, 2011). Despite this, policy documents continue to emphasise such approaches. Martin et al., (2015) suggest this may be because the concept reinforces the fantasy that it represents – i.e. that the reason for leadership failings is because ‘others’ have not enacted distributed approaches. It creates an ‘us’ versus ‘them’ in policy implementation and practice and assumes barriers will automatically cease to exist, without actively working to confront them.

Overall, there does seem to be a movement towards a consideration of a variety of leadership approaches within the NHS, perhaps as part of a ‘hybrid’ approach alongside traditional hierarchies (Hunter et al., 2015), which offers some encouragement for voluntary sector involvement. The
current public sector policy drive for greater collaboration with other sectors also offers opportunities for voluntary sector contribution. The next section will detail how voluntary sector organisations can take advantage of these opportunities in order to ‘make things happen’ (Huxham and Vangen, 1996; 2000a) in collaborative contexts, even in the face of significant restrictions.

3.4.4 Leadership Insights from the Collaboration Literature

Despite suggestions to the contrary (Kramer et al., 2018) there is a variety of literature that focuses on leadership in collaborative contexts in both the USA (Crosby and Bryson, 2005; Gazley, 2010; Ospina and Foldy, 2015) and UK (Huxham and Vangen, 1996; 2000a; 2005; Vangen and Huxham, 2003b). I will focus on the UK research in this review as that is where my research is based, however I will also refer to some of the insights from the USA literature around collective and relational forms of leadership as they have heavily influenced the UK context (Martin et al., 2015).

Huxham and Vangen (2005) suggest that within collaborative environments leadership is concerned with “the mechanisms that lead to the actual outcomes of a collaboration” (p.75 – italics original). This is a helpful definition as it allows for both positive and negative contributions to be acknowledged, avoiding one of the key criticisms of leadership studies more generally in that it is often biased towards the positive (Alvesson, 2017). A focus on ‘actual outcomes’ also emphasises that what matters is what happens in practice. This results in a pragmatic and contingent approach to leadership (Diamond and Vangen, 2017) which acknowledges the need to work both facilitatively - ‘in the spirit of collaboration’ - and in a more directive or authoritative way – “collaborative thuggery” (Vangen and Huxham, 2003b) - in order to ‘make things happen’. This distinguishes leadership for collaboration from ‘collaborative leadership’ in that the latter is focussed on collaborative approaches to leadership in a more idealistic sense – that leadership should always be ‘in the spirit of collaboration’ (see Chrislip and Larson, 1994). It is not the case however that all collaborations are free of authoritative hierarchy, notably they may be essential when dealing with emergency situations (Waugh and Streib, 2006; Murphy and Greenhalgh, 2018). Therefore, perhaps rather than
being entirely absent it may be that collaborations have a greater or lesser influence from hierarchical aspects depending on their structures (Vangen and Huxham, 2003a; Huxham and Vangen, 2004).

Huxham and Vangen (2000a; 2005; Vangen and Huxham 2003b) use the phrase ‘making things happen’ to describe a pragmatic approach to leadership that considers both facilitative and directive elements and have shown how the voluntary sector can play a leadership role in such settings (Huxham and Vangen, 1996).

3.4.4.1 Making Things Happen

Making things happen relies on a diversity of leadership approaches that Vangen and Huxham (2003b) suggest can be grouped into either ‘facilitative’ or ‘directive’ aspects. Working ‘in the spirit of collaboration’ – facilitatively - involves enacting four elements of leadership (Vangen and Huxham, 2003b):

- **Embracing** – working to include stakeholders, often in a targeted way. Involving the community; defining what that community is and inducting new representatives; fostering collaborative activity when members may not be fully onboard.

- **Empowering** – Enabling participation both in the collaboration itself and within the elements of that collaboration, such as ensuring meetings are open to all, encouraging interaction, ensuring communication flows well, particularly in relation to decision making.

- **Involving** – Building trust, managing inequalities of power between members, managing bias and conflicts of interest.

- **Mobilizing** – being sensitive to what incentivises individual organisations, bringing people together in face-to-face situations (workshops, seminars etc.) allowing them to negotiate, communicate and commit.

In contrast, aspects of ‘collaborative thuggery’ – directive leadership - include:
• **Manipulating the collaborative agenda** – influencing how issues are framed and taken forward, directly, or indirectly, aimed at progressing the collaboration through persuasion and an infiltration of one person’s ideas into the ideas of other individuals or the group.

• **Playing the politics** – deciding what needs to be done, who is worth the bother to involve and pragmatically forcing people out if they are deemed not worth the effort. Getting people and organisations ‘on side’, finding out who influences who and linking the collaboration itself into the right networks.

The notion of ‘thuggery’ is helpful in legitimizing a certain amount of manipulation and “going behind people’s backs in a trustworthy kind of way” (Vangen and Huxham, 2003b, p.74) or using ‘Machiavellian tactics’ (Chrislip and Larson, 1994). Additionally, organisations in collaborative environments have the twin goal of achieving the interests of the collaboration itself and the interests of their own organisations.

The notion of facilitative leadership echoes ‘collective’ approaches to leadership seen in general leadership theory (primarily from a USA context) such as ‘distributed leadership’ which was discussed in Section 3.4.3. More generally, collective leadership theories locate leadership itself away from the individual ‘leader’ and focuses on “the processes and practices that make leadership work evident” (Ospina, 2016, p. 281). This builds on notions of ‘relational leadership’ - which “focuses on the relational processes by which leadership is produced and enabled” (Uhl-Bien, 2006, p.667) - but goes further to position leadership within the system of relationships – the ‘in-between space’ (Biehl, 2018) that is full of ‘entangled’ actions (Quick, 2015). This is one level up from the individual and/or the relationships between individuals (Ospina, 2016). Individual leaders still have a voice within this conception of leadership – and it may be a powerful one - but it is one of many. These notions of leadership also equate the subject with a way of ‘being’ rather than a way of ‘acting’ (Cunliffe and Eriksen, 2011). This in recent years has influenced approaches to Leadership-As-Practice – L-A-P (see Raelin, 2011; 2016; 2017; Raelin et al., 2018) – which also focuses on the pragmatic outcomes of
action and the social interactions that lead to them (Raelin, 2011). However, L-A-P has been criticised for ignoring power dynamics in these social interactions and for not acknowledging the previous literature that has approached leadership in a similar way, particularly in the field of Critical Leadership Studies (Collinson, 2017; 2018). As the previous section has made clear, power dynamics are crucial in collaborative contexts.

The advantage of acknowledging the existence of ‘directive’ approaches is that it foregrounds a focus on which individuals or organisations have power. Manipulation and political manoeuvrings – ‘thuggery’ – are likely to take precedence in attempts to enact leadership. Organisations can also engage in ‘collaborative disruption’ – impacting on the running of the collaboration in order to satisfy their own self-interest (Jacklin-Jarvis, 2014). Acknowledging the possibility of acting in a disruptive and/or thuggish way can help to overcome some of the fear that can be created in practice by suggesting individualism and hierarchy are not relevant, creating a vacuum of uncertainty (Bauman, 2006).

Although Vangen and Huxham (2003b; also, Huxham and Vangen, 2000a) acknowledge that the facilitative-directive approach mirrors other dichotomies in theories of leadership, such as transactional vs. transformational or autocratic vs. democratic, they suggest participants in collaborations have to enact both aspects of leadership at the same time. This highlights the complex nature of leadership in collaborative settings and has parallels with ‘ambidextrous’ (Rosing et al., 2011; Zacher et al., 2014; Pina e Cunha et al., 2015) ‘hybrid’ (Gronn, 2009; Quick 2015) and ‘complex’ (Burns, 2002; 2008; Uhl-Bien et al., 2007; Uhl-Bien and Arena, 2017) forms of leadership in the general leadership literature.

In a UK public service context, Currie et al., (2009) acknowledge the competing ‘institutions’ of leadership focussed on individual accountability – i.e. leaders at the top of hierarchies – on the one hand, and aspects of distributed leadership and shared responsibility on the other. They suggest that this creates an impossible choice for practitioners. Although their research focuses on education, the authors speculate there may be similar pressures in a healthcare setting. These pressures can also
change over time in collaborative projects and Kramer et al. (2018) suggest more managerial (directive) approaches to leadership will emerge as projects come to an end. Equally, directive approaches may also be necessary right at the start of projects in order to take advantage of ‘collaborative windows’; Takahashi and Smutny (2002) suggest distributed forms of leadership “preclude rapid responses” (p.178) to such collaborative opportunities, despite being highly democratic. If the voluntary sector does in fact work in less hierarchical and more democratic ways as some of the assumptions about the sector would suggest, they may be in a worse place to enact leadership within settings that require more directive approaches. The need to deal with such pressures and tensions emphasises the pragmatic nature of viewing leadership as ‘making things happen’.

3.4.5 Summary of Leadership Section

In summary, leadership has been a relatively neglected subject in voluntary sector research. Much of the recent academic and grey literature has focussed either on leadership of the sector as a whole in a strategic sense, or on improving the skills of individuals in formal leadership positions. However, there have been acknowledgements, and attempts, to open up leadership beyond these restrictions. Austerity has created greater pressures for the sector around mission/values, survival, and collaboration which act as a triple leadership dynamic. This pressure has emerged at a time when capacity and funding are being stretched. Working collaboratively has been emphasised as a solution to these pressures, despite a lack of evidence for its efficacy (O’Leary and Bingham, 2009). Notions of collaboration are driven by New Public Governance pressures and a desire to enable bottom-up community co-production. This in turn foregrounds the leadership role of community representatives.

There is also a lack of research into the leadership role voluntary sector organisations can play when working with the NHS although there are hints in the literature that there should be some space for the sector. The NHS in a general sense has seen various attempts to move towards more
collective/shared/distributed forms of leadership but persistent hierarchies make this difficult. In addition, much of this effort is focussed at clinicians who are unlikely to interface regularly with the voluntary sector. This creates issues for the sector when attempting to enact leadership.

Huxham and Vangen’s notion of leadership in collaborations as ‘making things happen’ is very useful in this context as it allows for both facilitative and directive forms of action and is inclusive of anyone who contributes to practice, regardless of position or organisation. This notion of leadership as a process is also reflected in the wider Leadership Studies literature in ‘relational’ and ‘leadership-as-practice’ approaches; and in work exploring ‘ambidextrous’ or ‘hybrid’ aspects of leadership that suggest both authoritative and collective approaches are necessary. In a UK public service context these two competing ‘institutions’ make the practice of leadership something of an impossible choice for people of all sectors.

3.5 Summary of Literature Review

This literature review has detailed the large change in public service delivery over recent decades and the increased involvement of voluntary sector organisations that has been part of successive public administration initiatives. In particular, New Public Management (NPM) has led to an increased emphasis on competition in the sector, both in terms of how organisations relate to each other and in terms of how funding is awarded. New Public Governance (NPG) has focussed attention on an even more ‘hands off’ approach from central government, and emphasised collaboration as a policy tool to address ‘wicked problems’. Within this, particular attention has been paid to co-production of services with both voluntary sector organisations and communities. Both NPM and NPG agendas have caused issues for the voluntary sector in terms of practice, and some writers have suggested these developments have led to increased government control over the sector both in terms of policy and in terms of institutional pressure to conform to public sector ways of working. Austerity politics has exacerbated many of these issues, not least because of funding cuts and a re-emphasis on collaboration both for service improvement and cost saving. This in turn has created additional
pressures on voluntary sector organisations to work as both a ‘route in’ to communities and a ‘voice for’ them, Albareda (2018) suggests this ‘transmission belt’ role creates significant tensions and is unattainable for most voluntary sector organisations, despite being the preference of public sector policy makers.

Collaborations are not easy, and the literature suggests most will fail. This is in part because of the complex trust and power relationships at play, and how both of these elements act upon control of and in collaborative contexts. Bachmann (2001) suggests there are different traditions of trust and power at play that reflect how each is embedded in personal or system levels. For the voluntary sector, which is traditionally seen as more open, flexible, and personal, this may create problems when engaging with the NHS which historically has been hierarchical, authoritative, and formalised.

The voluntary sector is seen as having a lot less power in collaborations with the public sector, not least because often collaborative initiatives are ‘convened’ by public sector organisations. However, such contexts offer opportunities for the voluntary sector to leverage different aspects of trust and power.

The decreased emphasis on traditional hierarchy or authority in collaborative approaches to public service delivery leads to questions around how leadership works in such contexts. This review has shown how the subject has largely been neglected in voluntary sector literature generally and specifically in relation to how the sector works with the NHS. Although there have been attempts to embrace a less formal and less individualistic form of leadership in favour of more collective and collaborative approaches, these have often failed due to the strong institutional preferences at work, particularly in the NHS. Insights from the literature on collaborations suggests leadership is about ‘making things happen’, regardless of position or hierarchy. This focus of leadership as a process has parallels in the Leadership Studies literature in relation to approaches that are ‘relational’, ‘distributed’, and ‘collaborative’. However, crucially in collaborations, both authoritative – ‘directive’ – and collective – ‘facilitative’ – forms of leadership may be necessary, often at the same time, in order to drive efforts forward. For the voluntary sector, it can be difficult to engage in collaborations
with the public sector to the level that is needed in order to take advantage of these opportunities, often because of capacity issues.

Although there is much in the literature that relates to the questions contained in this thesis, it mostly does not provide empirical insight into the role of the voluntary sector in practice or focus specifically on trust, power, control, or leadership in collaborative contexts. My research will address these gaps by employing a research design that is informed by both ethnographic and action research traditions in order to answer the given research questions. The next chapter will explain the research approach in detail.
Chapter 4. Research Design

4.1 Introduction to Chapter 4

The design of any research project is the fundamental structure and plan that directs how it will be carried out (Bryman and Becker, 2012; de Vaus, 2001). Research design is a choice (Blaikie, 2000; 2007; Gorard, 2013) that should be made in line with whichever approach fits the aims of the research in question. This chapter will address several different aspects involved in the design of my research, in particular, it will cover the pragmatic approach to ontology and epistemology taken in order to enable a focus on practice; the influence of my own position and values as a researcher; the ethical considerations involved; the methodology of the research; and finally, how reflexivity was used to engage with aspects of researcher influence, aid interpretation of research data, navigate ethical issues, and ensure quality.

Before considering these aspects, it is necessary to start with the initial impetus for the research, which was to find out ‘what?’ was happening within the context of Wellbeing Erewash as a project, and specifically ‘how?’ the voluntary sector was working within that context. This initial impetus influences both the research purpose and formal research questions (Wengraf, 2001) and in order to answer those questions this research adopts a flexible and iterative research design, in line with engaged research approaches. ‘Engaged’ in this thesis means utilising methods that emphasise researcher involvement in the research context, what would in Action Research traditions be termed ‘intervention’ (Coghlan and Brannick, 2010) or in Ethnography ‘participation’ (Moeran, 2009).

Although all aspects of Research Design involve choices taken by the researcher it is important to acknowledge the factors that influence those choices. The ‘research purpose’ of this research is highly influenced by my personal background and experiences – my axiology – which act as ‘shortcuts’ (Moore, 2000) to other aspects of the research design. Each element flows from this initial starting point in a logical fashion. Foregrounding the researcher position in this way is another hallmark of
engaged research and necessitates the use of reflexivity – detailed in Section 4.8 – in order to navigate the tensions and conflicts that this can create (Blaikie 2000).

The choices made by researchers are a matter of ontological and epistemological position, whether implicitly or explicitly (Lohse, 2017) and these positions have a long history and influence over academic attempts to understand the social world. As such it is necessary to consider these aspects in order to make clear what the research is claiming and ensure quality and rigour within the chosen approach. This research adopts Pragmatism as ontology and epistemology as Section 4.2 details. This in part includes a rejection of the importance of both terms and as a result they are used in this research as placeholders or signposts to allow the reader to contextualise the discussion in wider academic debates. Engaged research approaches necessitate a consideration of the ethical implications, particularly in relation to the interactions between and impact on researchers and participants. These interactions are dictated by the data collection methods employed and as my research adopts a very broad approach to data, providing a clear account of the methodology employed is important. Section 4.7 provides more detail on this including the types of data collected, the precedence given to different data types and how a triangulation of the data sources contributes to the validity of the research. This section also details the aspects of researcher position that made reflexivity an essential aspect of the research design in order to track ethical aspects and to surface the axiological influence at play in my role as researcher. Reflexivity is explored in Section 4.8.

4.2 Ontology

“Ontology is the study of being, that is, the nature of existence and what constitutes reality” (Gray, 2014, p.19; also see Klenke, 2014; Saunders et al., 2015). Adopting a specific ontology can provide a firm basis for decisions taken about research design, including the choice of research methods, and provide a grounding for the claims made about any research, including whether or how they can be generalised. Debates about the value of adopting a specific ontological position are ongoing, and the quest to reach consensus has not been successful (Peters et al., 2013). Several writers have
questioned the value of adopting an explicit ontological position and point out that doing so does not automatically lead to good quality research (Mir and Watson, 2001; Silverman, 2011; Lohse, 2017). Going even further, Tsilipakos (2012) concludes that ontological debates are ultimately pointless and that they do little to make any differences between research traditions any clearer.

I side with the literature that downplays the importance of ontology and that questions the relevance to practice of the ongoing debates between different positions. Saunders et al. (2015) suggest that for researchers holding this viewpoint ‘Pragmatism’ may be a suitable grounding as it enables a consideration of the issues of ontology but does not involve a restrictive choice of position or the “rather pointless debates about such concepts as truth and reality” (p.12). For the purposes of my research, adopting an approach informed by Pragmatism means having a focus on ‘relevance-to-practice’ (Watson, 2011) and on the context under investigation. Table 4-1 below (p.105) gives an overview of the different elements of adopting a Pragmatic approach to research, presented within the typical research design structure.

Table 4-1 - Elements of Pragmatism

<table>
<thead>
<tr>
<th>Ontology (nature of reality or being)</th>
<th>Epistemology (what constitutes as acceptable knowledge)</th>
<th>Axiology (role of values)</th>
<th>Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complex, rich, external</td>
<td>Practical meaning of knowledge in specific contexts</td>
<td>Value-driven research</td>
<td>Follow research problem and research question(s)</td>
</tr>
<tr>
<td>‘Reality’ is the practical consequences of ideas</td>
<td>‘True’ theories and knowledge are those that enable successful action</td>
<td>Research initiated by researcher’s doubts and beliefs</td>
<td>Range of possible methods: mixed, qualitative, quantitative, action research</td>
</tr>
<tr>
<td>Flux of processes, experiences, and practices.</td>
<td>Focus on problems, practices, and relevance</td>
<td>Researcher reflexive.</td>
<td>Emphasis on practical solutions and outcomes.</td>
</tr>
<tr>
<td>Problem solving and informed future practice as the contribution/outcome.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: Adapted from Saunders et al., 2015, p.137)
Chapter 4 Research Design

Pragmatism attempts to close the gap between theory and practice by focusing on the practical implications of any research (Harwood and Eaves, 2018). Pragmatism views whichever tool (or method) is most appropriate for the job as the defining factor in assessing suitability of approach, regardless of its metaphysical essence. As Menand puts it:

> When your fork proves inadequate to the task of eating soup, it makes little sense to argue about whether there is something inherent in the nature of forks or something inherent in the nature of soup that accounts for the failure. You just reach for a spoon. (Menand 2001, 361, in Kivinen and Piirinen, 2006, p.322)

Pragmatism also allows for the researcher to be drawn into the research design at the initial phase, foregrounding them as a part of the research process and placing importance on researcher agency and the limitations of both the research itself and the human actor’s point of view (Kivinen and Piirinen, 2006).

It is important to note that adopting a pragmatist approach can be viewed as rejecting the terms ontology and epistemology (Kivinen and Piirinen, 2006). I am choosing to conceptualise it as an ontological choice (as in Table 4-1, p.105) in order to be clear about the approach and to feed into structured discussions about epistemology and methodology.

To summarise, adopting a pragmatic approach to the research allows for a focus on practice within a specific context, while enabling any value or ‘truth’ of claims to be judged as more or less useful within those contexts (or other similar ones). It allows for the researcher to be foregrounded both in terms of the impetus for the research – which in this case grew out of my own experiences as a practitioner - and in relation to their ongoing role as part of the research process. As such, it is also consistent with the engaged research methods adopted in this research (Pratt, 2016).

4.3 Epistemology

"Epistemology provides a philosophical background for deciding what kinds of knowledge are legitimate and adequate." (Gray, 2014, p. 19) It “concerns assumptions about knowledge... and how we can communicate knowledge to others." (Saunders et al., 2015). As implied above, adopting a
pragmatic approach can be associated with either a complete rejection of ontology or of collapsing ontology into epistemology (Pratt, 2016). Table 4-1 above (p.105) identifies the overlap between the two aspects in its first two columns – a focus on the practical value of ideas and knowledge. In this sense, adopting such a position has similar consequences epistemologically as it does ontologically. Specifically, in relation to what kinds of knowledge are deemed legitimate, it is the knowledge that has relevance to practice. Epistemological approaches should therefore be adopted that allow an investigation of the practices of any context. Interventionist approaches generally (Harwood and Eaves, 2018) and Action Research approaches in particular have been put forward as enabling this (Eden and Huxham, 1996; Málovics et al., 2018) because of their connection with, and impact on, social practice and the way that “the logic of action is constituted in the inquiry process and guides the knowledge generation process.” (Levin and Greenwood, 2001, p. 104). However, in order to garner a full picture of any particular research context – which is especially important in asking ‘how?’ or ‘why?’ a situation is as it is – it may also be necessary to collect additional data that does not reflect immediate practice, to build up a multi-layered dataset and therefore ensure any research is robust. This is the notion of ‘triangulation’ in engaged research (Eden and Huxham, 1996; 2006) and fits with the pragmatic commitment to ‘holism’, i.e. attempting to understand the wholeness of a research context (Levin and Greenwood, 2001; Pratt, 2016).

For the purposes of this research, the approach to what counts as knowledge is a broad one. There is an overarching emphasis on practice and the data generated from practice methods as Chapter 5 - Analysis will show, however, in order to meet the requirement for triangulation in engaged research, data will also be collected in relation to official documented accounts of the context in question and individuals will be interviewed in order to capture their interpretations of practice. This approach is valid pragmatically as all of these sources help to develop a better picture of the practice context and understanding this context holistically means research findings will be better informed and more likely to be useful to practitioners, because of their direct link to practice. This is in contrast to other research approaches, such as theory testing, which rely on positivist notions of ontology and
epistemology, that do not provide for the same flexibility of method, and so also do not provide the same insight into practice.

### 4.4 Axiology

As much as any research approach is about choice (Blaikie, 2007) it is as much about the pre-conceptions inherent within the researcher and the context in which they operate – their axiology (Klenke, 2014). "Axiology refers to the role of values and ethics within the research process. This incorporates questions about how we, as researchers, deal with both our own values and those of our research participants." (Saunders et al., 2015, p.128). This section will consider the values that I as a researcher brought to the research and their potential impact upon the process. Ethical considerations are discussed in Section 4.6.

Firstly, it’s important to note that my interest in this research grew out of practice. I had previously worked in the area; had links with individuals and organisations; and had a knowledge of a variety of contextual issues. I also had some common values with my research participants, developed through our shared practice. Although never explicitly defined, these values centred around a commitment to the voluntary sector; to supporting local people; and to working together to effect change. These links were important not only to inform practical elements of my research – access to context/participants and familiarisation with the data most notably – but also to inform my general approach, including a focus on what actually happens in practice, which in turn led to the suitability of Pragmatism as an ontological and epistemological foundation. As Klenke (2014) notes, Axiology reflects Ontology, Epistemology and Methodology within the research process generally. However, within engaged research in which the researcher’s role is (unavoidably) emphasised, it is arguably the case that Axiology informs Ontology, seeing as the background of the researcher informs the choices made.

Secondly, as much as I have a professional connection to the research, I also have a personal connection – and emotional tie – to the local area, having lived in Derbyshire for most of my life.
Maile (2015) suggests that researchers tend to avoid researching ‘where they’re from’ because of the emotional difficulty involved, both in the sense that it can be stressful and also that researchers can be bored by the familiar. Trussell (2014) notes that it is easier to explore the vulnerabilities of others than it is to expose our own, which suggests that it would be very difficult to carry out a study in which our participants’ and our own vulnerabilities are one and the same. However, for me, the connection to my life outside the research was an important motivation in the first instance. Maile (2015) points to certain advantages of having this additional insight, including both understanding the research context and understanding ourselves (as part of it) at the same time. This can help to reduce the ‘othering’ and potential exploitation of research participants and in turn help to bridge the subjective/objective dichotomy by situating the research as a process of joint meaning-making. Within this research I was certainly able to take advantage of my previous knowledge to develop greater access and camaraderie with my participants, particularly through using irony and humour to demonstrate insider knowledge – talking on the same wavelength - equalising my status with participants and opening up communication (Greenwood and Levin, 1998).

Alvesson (2009) suggests ‘at-home ethnography’ – i.e. research into something you’re highly involved in - can provide insights related to the intimate knowledge that has built up over time and that is not available to complete outsiders. ‘At-home’ ethnographers rely on their familiarity with a setting as an empirical starting point. The ‘trick’ then is to think through that understanding that may be taken for granted in order to develop a full description and theoretically relevant ideas. However, there is often a choice to be made between the two. Reason and Torbert (2001) note that knowledge is experiential, grounded in “our own presence in the world, and our encounter with the presence of other” (p.11). They suggest it is essential for researchers to ‘feel’ their research. Such acknowledged emotional ties obviously lead to questions around bias and whether certain decisions and interpretations are made during the research process that could impact on the validity of the research, however, Vincett (2018) draws attention to the benefits that can come through acknowledging the emotional impact of research on both participants and researchers alike and how
the process of ‘going native’ can actually bring additional insights into practice environments. They do note the strain this can cause however and the need to maintain a high level of self-care throughout. Finally, in relation to axiology, I have to acknowledge my position as an academic researcher and the influence of the academic tradition on my approach to the research. Most notably, this includes an inescapable separation between myself and the practice I am investigating, despite the connections identified above. Bourdieu (Bourdieu and Wacquant, 1992) notes that there is a need to “objectivize the objectivizing point of view” (p.69) through the process of ‘objectivation’. This approach has faced criticism for implying realist notion of ‘truth’ – in this case a relational truth through a ‘Theory of Practice’ - rather than having a focus on developing theories as part of a “practicable toolset” (Kivinen and Piirainen, 2006, p. 319). Nevertheless, drawing attention to the notion of academic position adds a further depth to notions of axiology as I would not be carrying out this research if I was not seeking to make a contribution to academic knowledge.

Navigating axiological, as well as ontological and epistemological elements of research necessitates the use of reflexivity in order to provide reassurance and this will be addressed in Section 4.8.

### 4.5 Unit of Analysis

The concept of ‘unit of analysis’ has different meanings depending on the approach taken in any research, notably in relation to the difference between research design in contrast to research methodology (Thomas, 2011). In keeping with the ontological and epistemological approach of pragmatism described above, a formal unit of analysis – that may be the basis of less flexible research approaches – is likely to vary in relation to both the design and the methodology of engaged research. However, much like the terminology of ‘ontology’ and ‘epistemology’ can be useful in considering research philosophies within the structure of a PhD thesis - even if the approach taken rejects that terminology - the terminology of ‘unit of analysis’ can also provide a helpful guide to the overall approach to the research. As such, although in a general sense my research adopts as its unit of analysis the Wellbeing Erewash (WE) project itself and the ‘level’ of that analysis is therefore focussed
on meso aspects (i.e. not micro level individualism or macro level concepts such as ‘the economy’ as a whole), it is necessary to unpack the complexity inherent in such a simplification, in order to do full justice to the approach and provide a level of detail that is necessary in order to judge the suitability of that approach (Gorard, 2013). The rest of this section will provide the detail in order to do this.

As the research in this thesis is focused on practice, Wellbeing Erewash (WE) as the unit of analysis is conceptualised as a collaborative entity in keeping with an approach in terms of research design that is a holistic ‘case study’ (Thomas, 2011, de Vaus, 2001). Within this, the unit of analysis has both a subject (the WE project) and an object (cross-sector collaboration); the units of observation are the stakeholders (individuals and organisations) and their interactions within the project (Thomas, 2011). This also feeds into notions of unit of analysis in the formal analytical phase of the research (how the data were coded) as described in Chapter 5 – Analysis, in that because of the flexible approach adopted, and the commitment to holism inherent in the case study research design, different aspects were focused upon at different times but analysed together in a thematic way. This has much in common with other approaches to ‘meso’ levels which utilise concepts such as the ‘activity system’ (Engeström, 2001), ‘network’ (Provan and Kenis, 2008), or ‘set of practices’ (Nicolini, 2012). The commonalities across these approaches is an understanding of analysis at the meso level as fundamentally about interactions, the collective, emergence, fluidity, relationality; and focused on the notion of ‘becoming’ in a developmental sense.

The unit of analysis of any research is also determined by the given research questions (Yin, 2014) and if we consider the iterative nature of the development of the questions for this research described in Section 4.7.1, we can see that although the unit of analysis in a general sense was indeed the project, the research questions are inclusive of multiple levels and interacting elements, from the ‘individual’ in relation to notions of leadership and trust, to the ‘organisational’ in relation to the role of Erewash Voluntary Action and the NHS as ‘convener’, and the ‘sectoral’ in considerations of different traditions of trust, power, and control across the public and voluntary sectors. In addition, as acknowledged in this thesis, the focus is on the voluntary sector role in WE, to the exclusion of
aspects of the project that the sector was not involved in. Chapter 2 – Context, and in particular
Section 2.7, describes these areas in detail. This exclusion may be problematic for a commitment to a
holistic case study ‘method’ but is not for a holistic case study ‘design’. The unit of analysis can
therefore be said to represent an ‘establishment’ (Salamon and Anheier, 1997) within the wider
organisational entity of the WE project – organisational entities being made up of many interacting
‘establishments’.
This is not to say that ‘practice’ is itself the exclusive unit of analysis as other aspects have been
included in this research that may not immediately fit with a philosophical commitment to practice-
based approaches. This reflects back to the adoption of pragmatism as the basis for this research in
that it allows the inclusion of different methods and associated ontologies without the need to switch
between traditions of research (and associated units of analysis) in a ‘messy’ way. Critics have also
suggested adopting practices as the fundamental unit of analysis can lead to issues of agency
(Simpson, 2009) and a lack of focus on wider issues such as structural and power dynamics (Collinson,
2017).
Despite this complexity, as stated above it is possible for the purposes of this thesis to state that the
unit of analysis is the Wellbeing Erewash project in a general sense, the unit of observation is the
stakeholders and their interactions within the project, and that therefore the analysis is at the meso
level.

4.6  Ethics

Approaches that involve direct action with practitioners in specific research environments are open to
criticism around the ethics of involvement and the potential harm that can be caused both to
participants (Brydon-Miller, 2008) and researchers (Humphrey, 2007). In particular, concerns around
anonymity and confidentiality are highlighted because of the close relationship between researcher
and researched and the ‘evolving’ nature of consent (Coghlan and Brannick, 2010). In addition,
carrying out research with people known to the researcher in a professional capacity carries risks in
relation to the professional identities of both researcher and participant (Radnor, 2001). My research, rather than trying to avoid any influence, actively engaged in interventions in practice, such as completing work for the organisations involved, facilitating workshops, and contributing to other meetings and events (as detailed in Section 4.7). The key issue therefore was to remain reflexive in relation to the effect of that influence on both the practice context and the research. This reflexivity was not just in the sense that my actions as a researcher were thought about and reflected upon, but also that I removed myself from the research environment on a regular basis and sought perspective both from physical and mental separations and through my engagement with others, particularly through discussions with my supervisors. Ethical approval to carry out the research was granted by The Open University’s Human Resource Ethics Committee (HREC).

Consent was sought from all participants who made an individual contribution to the research that could be directly attributed to them. This included those with whom an informal conversation had taken place, all staff members of Erewash Voluntary Action (EVA), and those who were formally interviewed. Consent was not sought from every individual in meetings and other events, for several reasons. Firstly, these were often public events; secondly, the interest of the research was not focussed on what specific individuals happened to say in any particular meeting/event; and thirdly, gaining consent from multiple – at times, dozens – of people would have been very difficult and disruptive on a practical level. Where consent has not been given no data are directly attributed to any individuals. I introduced myself and made everyone aware I was carrying out research before every meeting and reassured participants that I would not be quoting any of them directly in my research. Interview participants were able to review transcripts in order to confirm their accuracy, however only two opted to do this and neither suggested any changes. All participants were made aware that they were able to withdraw from the research until 31st October 2018.

No significant ethical issues were encountered when carrying out the research. No participants removed themselves from the research and access was given to almost all of the research context (the one exception is detailed in Chapter 6 – Findings). I did have to consider how to record sensitive
discussions or revelations in my field notes. At times individuals made comments to me that were critical of other individuals or organisations. I mainly chose not to record the specifics of these comments in my notes unless they had direct relevance to the (emerging) research questions (none did). Similarly, I was privy to discussions in relation to potentially sensitive financial and/or organisational issues, such as at planning meetings, again, I chose not to record the specifics but rather the general context of the discussion and whether anything was said or done that was relevant to the focus of the research. Erewash Voluntary Action were very enthusiastic to have their name attached to the research and so I had to make it clear when discussing their participation that both positive and negative findings were possible.

Engaged forms of research carry risks around the role duality in relation to the different positions of ‘researcher’ and ‘participant’ (Brannick and Coghlan, 2007); the vulnerability of ‘going native’ (Fine and Hallett, 2014); and – as mentioned above – the issue of emotional connections and ties to the research area (Alvesson, 2009; Maile, 2015). As such, it is important for the researcher to take ‘time out’ from the field in order to maintain a link to and focus on the academic world (Moeran, 2009). Alvesson (2009) suggests rather than the risk being ‘going native’ it is actually ‘staying native’ and being unable to reconnect back with the academic community. Alvesson warns that, particularly for PhD students, the twin process of being socialized into both the academic research community, and the community being studied, can be difficult. In order to avoid these issues, I scheduled regular meetings with my academic supervisors and a break of several weeks in the middle of the field work in order to reflect and to complete my PhD Probation Report. A full discussion regarding researcher position is in Section 4.7.8.

4.7 Methodology

Adopting Pragmatism as an ontological and epistemological basis for this research suggests taking a methodological approach that focuses on gathering data in practice, or as close to practice as possible. This in turn pushes research towards ‘engaged’ approaches that imply a high level of direct
involvement, or even intervention, within a research context. Two methodological traditions that allow for such involvement and intervention and that therefore have informed the methodology of my research are Action Research and Ethnography. Both of these approaches have been carried out with Pragmatism as their basis (Greenwood and Levin, 1998; Levin and Greenwood, 2001; Watson, 2011). My research combines the focus on practice and intervention of Action Research with the attention to observation and participation of ethnography. In this sense it is related to approaches that combine the two, such as ‘Action Ethnography’ (Cole, 2005; Eden and Huxham, 2006), and ‘Ethnographic Action Research’ (Tacchi et al., 2003; Bath, 2009). Specifically, this research is informed by the Research Oriented-Action Research (RO-AR) strand of Action Research (Eden and Huxham, 1996; 2006; Eden and Ackermann, 2018) which has acknowledged similarities with ethnography and practice ontology (Vangen, 2017). Unlike other forms of Action Research, RO-AR allows for more of a focus on research output and less of an emphasis on the involvement of research participants in the research intervention. It may be that practitioners in a context are involved in the research intervention (as well as the practice intervention) throughout, but they don’t have to be like they would in other approaches, such as Participatory Action Research (Reason and Bradbury, 2008a). RO-AR suggests that because the results generated from any research intervention cannot help action within the situation that they are generated, the action and research agendas, although interdependent, are separate. As the research context, organizations, and some participants were known to me before the research began, I was an ‘active’ member of the research environment. However, because of the variety of different events and meetings that took place in the practice context my role was not the same at all times and in fact ran the gamut between ‘complete’ and ‘no’ participation. More detail on researcher position follows in Section 4.7.8.

4.7.1 Developing Research Questions

In engaged forms of research, research questions (RQs) are iterative and emergent (Levin and Greenwood, 2001; Stringer, 2007). They can be developed in ‘cycles’ (Reason and Bradbury, 2008b) or
as part of the process of familiarization within the research context over time (Tacchi et al., 2003). This is often not a neat or smooth process, and can be quite messy (Kenneally, 2013). It is also perfectly possible for studies to begin, and even continue for a long time, without any formal research questions at all (Watson, 2011), although this necessitates the systematic and detailed use of reflexivity in the research process (Eden and Huxham, 1996). Despite this, all enquiry has to start with a general question or aim that is the reason for embarking on the research in the first place – what Moore (2000) has termed a ‘shortcut’ to doing the research and what Wengraf (2001) terms a ‘research purpose’. This general purpose then leads to the development of a ‘central research question’ (Wengraf, 2001), which begins to structure the enquiry process and then more formal research questions. In engaged research these questions become refined as the research progresses (Stringer, 2007).

My research started with the desire to know more about how the voluntary sector worked with the NHS in the Wellbeing Erewash project – that was the research purpose. The initial central research question is therefore a ‘what?’ question, specifically: ‘what is happening in relation to the way the voluntary sector is working in the Wellbeing Erewash project?’. My experience as a practitioner (see Section 4.4) informed several initial sub-questions below this central one in relation to whether the relationship between the NHS and the voluntary sector was one of equals or exploitation; whether the voluntary sector could enact leadership in such a collaborative context; how personal relationships played a role in the project; and how the interaction between formal policy and informal practice worked. These acted as cues to be aware of during data collection. Over time, through interactions with the practice context; my own reflexivity; and crucially, analysis of the data, these cues inductively developed into the emerging themes of the research. Two crucial points in the design of the research had an influence on this process:

1) Having a gap of several weeks away from the field in the middle of the research had two influencing roles. It allowed me some time to reflect on what was developing from the data in an informal way and to refine my research questions accordingly in order to structure the
second half of the data collection. Also, writing my PhD Probation Report in that period – as a requirement of progression in my degree – meant that I started to put together more formal research questions that both summarized what I had done and suggested how the research might progress. Having to consider some initial findings helped to structure this.

2) A decision was made during data collection to leave all formal analysis (i.e. the coding process using NVivo software) to the end of the data collection. This decision was taken mainly for reasons of capacity as I did not feel I had the time to dedicate to analysis whilst also paying full attention to the data collection itself. This differentiates the research from most, if not all, Action Research approaches that emphasize cycles of data collection and analysis, but it is quite common in ethnographic research approaches. The result of this in terms of influence on research questions is that the questions did not directly drive data collection or analysis because the approach taken was an inductive one. Themes developed iteratively from the data through the analytical process.

The research questions for this thesis emerged through a process of attempting to explain the themes that developed from the data with the literature that I was engaging with. This process of inductive, thematic analysis (see Chapter 5 – Analysis) resulted in the final research questions, as follows:

1) What was the role of the voluntary sector in Wellbeing Erewash?

2) How did trust, power, and control play out in this collaborative context?

3) In what ways was the voluntary sector able to contribute to leadership and ‘make things happen’ in the project?
Figure 4.1 (p.118) shows the process of arriving at these questions.

**Figure 4.1 - Developing Research Questions**

**Developing Research Questions**

**RESEARCH PURPOSE**

‘How is the voluntary sector working in the Wellbeing Erewash project?’
- Informed by practice
- Plus, initial literature

**Themes develop through analysis:**
- Voluntary Sector Profile
- Control
- The Individual versus the Community
- Leadership

**Sub-questions:**
- Is the relationship between the NHS and voluntary sector one of equals or of exploitation?
- Can the voluntary sector enact leadership in this context?
- What role do personal relationships play in how the project works?
- To what extent does practice reflect policy?

**Act as cues for data collection**

**Themes finalised for thesis**

**Final interrelated questions, relevant to themes:**

1) What was the role of the voluntary sector in Wellbeing Erewash?
2) How did trust, power, and control play out in this collaborative context?
3) In what ways was the voluntary sector able to contribute to leadership and ‘make things happen’ in the project?

(Source: created by author based on process of research question development)

**4.7.2 Data Collection Methods**

The fieldwork for this research took place over a twelve-month period from April 2017 to March 2018. This coincided with the final year (of three) of the Wellbeing Erewash (WE) project. Erewash Voluntary Action (EVA) were kind enough to ‘host’ me during this period as I had negotiated access to the project through them. They gave me use of a desk and computer. The data collection was split into two parts: the first six months were spent working at EVA, I was ‘in the office’ three or four days each week and worked on various aspects of WE, including collating EVA’s Quality for Health application; contributing to meetings and events; helping to facilitate community days; inputting into the development of the Community Connectors project; and a variety of other day-to-day activities.
Chapter 4 Research Design

At the end of August 2017, I took some time off from work in the field to reflect on how data collection had progressed, to informally assess some initial findings, identify any changes that were needed, and to complete my PhD Probation Report. As a result of this reflection, I concluded that although I had a good representation of what the voluntary sector (mainly EVA) had contributed to the WE project, I had less information about the NHS side and how the process of interaction between the two sectors worked at a strategic level. The second six months involved a widening of the data collection in order to address this.

The second six months of data collection included attending formal NHS meetings more regularly, in particular through gaining access to the newly developed ‘Alliance Leadership Team’. I also decided at this stage to formally interview some of the key actors from the WE project that I had identified during the previous six month’s data collection. I continued to spend time ‘in the office’ at EVA, and to attend and contribute to meetings and events, but I did not contribute as much specifically to the organisation itself.

4.7.3 Types of Data Collected

Various types of data were collected during this research, in line with engaged research approaches (Kenneally, 2013). This included: Field Notes from participant observation and observant participation (from days at EVA, official WE meetings, other related events); notes from informal conversations/personal meetings; interview notes and transcripts; and documents produced through the WE project and beyond (including minutes, agendas, newsletters, tweets etc.). In total, the data imported into NVivo for analysis that I personally created during fieldwork amounted to 465 pages of text and 271,455 words. A breakdown of this is in Table 4-2 below (p.120).
Chapter 4 Research Design

Table 4.2 - Types of Data Collected

<table>
<thead>
<tr>
<th>Data Source</th>
<th>What it's made up of</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days ‘in the office’</td>
<td>64 days ‘in the office’, 120 pages of data, 41,533 words</td>
</tr>
<tr>
<td>Meetings/events</td>
<td>45 meetings/events, 145 pages of data, 56,831 words</td>
</tr>
<tr>
<td>Interview transcripts</td>
<td>16 interviews, 234 pages, 145,612 words</td>
</tr>
<tr>
<td>Interview notes</td>
<td>16 interviews, 22 pages, 5604 words</td>
</tr>
<tr>
<td>Personal meetings</td>
<td>8 personal meetings, 20 pages, 7003 words</td>
</tr>
<tr>
<td>Tweets and screengrabs</td>
<td>5 captured tweets/screengrabs, 6 pages, 277 words</td>
</tr>
<tr>
<td>Vignettes</td>
<td>4 vignettes, 17 pages, 4773 words</td>
</tr>
<tr>
<td>Naturally occurring data</td>
<td>95 documents of various types and length</td>
</tr>
</tbody>
</table>

(Source: created by author based on total data collected)

In addition to this, there were a variety of other data analysed in NVivo, which can be described as ‘naturally occurring’ – i.e. produced by the project itself - including newsletters; promotional documents; reports etc. This amounted to 95 other documents of varying lengths.

The detail of all the different types of data is as follows:

1) **Field Notes** – field notes from participant observation or observant participation made up the bulk of the data collected. These were handwritten in a notebook and then typed into Word either the same day or shortly afterwards, depending on my capacity. At times, involvement in events meant initial handwritten notes were quite brief, these acted as cues that were then added to immediately after the event. The notes were gathered from multiple different contexts in practice, including:

- **Days at Erewash Voluntary Action (EVA)** – These notes are from days ‘in the office’ at EVA. They contain observations regarding the general functioning of the organisation. The notes are very general in that I made a commitment to attempt to record everything that happened whilst I was in the office. They capture the planning and the aftermath of events relating to Wellbeing Erewash and it is those notes in particular that were useful for this research. Often, I was very involved as a participant, making it difficult to write in great detail, in those
instances having a desk and space to work in the office was very useful as I could take
advantage of quieter periods to write in more detail. The notes include descriptions of things
that happened; the response of people involved; links to other aspects of data; initial
interpretations; and reflections on both the relevance for research and my own reactions as a
researcher.

- **Meetings and Events** – These notes were from specific meetings and events. They vary from
events that I was wholly involved in as a participant – such as a training session on eating
disorders held at EVA – to meetings that I was entirely an observer at, like the ‘Alliance
Leadership Team’ meetings held at Erewash CCG. Again, these notes are varied in their
content depending on the nature of my involvement, and of the event itself. For example,
notes on ‘Community Days’ contained more observations about interactions and emotions,
whereas the notes on the NHS meetings are more descriptive of processes and procedures.
This reflects both the detail of the events themselves and my reaction to them as a
researcher.

- **Vignettes** – These were notes that captured a particular issue. Because these were often fast-
moving or heavily contextually dependent, it was very difficult to capture the exact detail as it
happened, and I was sometimes not able to ‘be there’ for every contributing element of each
issue. As such, these vignettes were developed from brief reflective notes that were written
up as part of other data, before being ‘fleshed out’ by adding other relevant information
along with a written commentary explaining the significance of each aspect.

2) **Other notes** – At times I was given access to records kept by others that I was not able to
make copies of and which therefore necessitated the capturing of as much information about
the data as possible during the short time access was available. These notes are more
analytical than other notes from the field as they contain observations, comments and
interpretations about potential research significance.
3) **Notes from Personal Meetings** – these meetings were not audio recorded, and so handwritten notes were kept as a record of what was discussed. The meetings were unstructured, beyond an initial question asking participants to explain their role, and as a result the content is quite general. Some of the discussion was not relevant to the WE project. These meetings were opportunistic, and participants were selected based on their proximity to the Wellbeing Erewash project and availability at any particular moment, i.e. most of these happened during spare time between or after meetings; free time between tasks in the office; over lunch etc. Although they provided some useful data the meetings also acted as a way to introduce myself as a researcher to participants in a private setting and to increase familiarisation and trust.

4) **Interview notes and Transcripts** – These formal interviews were arranged in the second period of field work (September 2017 to March 2018). The participants were identified during the first period of data collection as people who had contributed to the ongoing work of the WE project. The interviews were audio recorded digitally and transcribed into Microsoft Word before being imported into NVivo for analysis. The interviews were unstructured and carried out in the form of casual conversations about the project. Some basic prompts were taken into the interview as a backup if conversation stalled but were rarely needed (see Appendices for an example list). Handwritten notes were kept throughout the interview in order to record interesting elements of the discussion to follow up either later in the conversation or outside of the interview.

5) **Documents** – A variety of different types of documents were produced throughout the project by all parties involved. As wide a variety of these documents as possible were included in the analysis. Notably:

- **Agendas and minutes from meetings** – These included the ‘official’ Wellbeing Erewash planning and strategy meetings (later the ‘Alliance Management’ and ‘Alliance Leadership’ team meetings) for which the documents were produced by NHS workers; and the materials
from the voluntary sector meetings that were run by Erewash voluntary Action. Most of this
data was in duplicate digital and physical form with the digital versions imported into NVivo
for analysis.

- **Newsletters** – The Wellbeing Erewash newsletters were produced by a Public Relations
organisation, under the guidance primarily of NHS workers. They contained information on a
variety of different aspects of the project, including some voluntary sector information. These
newsletters were in digital format and imported into NVivo for analysis.

- **Planning Documents, Reports and evaluations** – various reports and evaluations were
produced throughout the project. These included sustainability reports produced by NHS
workers; a project evaluation carried out by a private consultant; and an evaluation of
Erewash Voluntary Action’s specific work on the project carried out by a different private
company. The planning documents included the initial project proposals and its updates
along with the descriptions of the various elements of the project. Reports were regularly
compiled to update Erewash CCG and NHS England on progress and in addition the RSA
(Royal Society of Arts) produced one focusing on the ‘Community Connectors’ work. These
documents were acquired in digital form and imported into NVivo for analysis.

- **Promotional materials** – promotional materials were produced locally by both the project
itself and the separate organisations involved within it, and nationally by NHS England and
other associated organisations. Of note are the ‘Info Guides’ produced to provide information
to others who might want to introduce similar ways of working in different contexts, and the
‘Vanguard Briefings’ which gave a national picture of how the vanguard projects had worked.
There was also an ‘Erewash Story’ produced by the same private PR firm who produced the
newsletter – after a consultation process with organisations and individuals involved with the
project – and various flyers, cards, and infographics detailing the work of the project. Again,
all of these materials were in digital form and imported into NVivo for analysis.
Tweets/screengrabs – emphasis was placed at different times on the use of technology to help deliver the project, particularly the use of Twitter to communicate. This was particularly useful to capture views of people involved in the project who were not accessible on a day-to-day basis. In addition, the Wellbeing Erewash website was a source of information about the project and so some information was captured from there, mainly in relation to official descriptions of the project. Each element that was captured in this way was imported into Microsoft Word along with a short description and a link to where it was found. These were then imported into NVivo for analysis. It’s important to note that all of this ‘online’ data was taken from publicly available sources.

Reflective notes were kept throughout data collection, in line with recommendations for engaged research. These notes primarily provided insight into the process of data collection but also acted as both a familiarisation tool and a way to spark initial analysis. Section 4.8 explores reflexivity in more detail.

4.7.4 Precedence Given to Different Data Types

Strom and Fagermoen (2012) state that field notes offer more ‘complete’ data than interviews as they are able to capture “where it happens” (p.542). In contrast, interviews are abstracted from the context in question. Alvesson (2009) suggests reliance on interview data above and beyond ethnographic data is problematic for representations of practice and Moeran (2009) suggests the richness of the data generated from ‘observant participation’ is of far greater value in representing practice than interviews alone. In addition, Nicolini (2009) states that a practice approach to research cannot rely wholly on interviews because they are not faithful to a ‘processual ontology’, i.e. they are static whereas practice is a process of ‘continuous flow’ (Crevani et al., 2010). However, interviews can - along with documents and other forms of data - considerably strengthen engaged approaches to research by allowing the exploration, questioning, and probing of specific issues in a controlled way by the researcher (Watson, 2011).
My research, in line with its pragmatist ontology, gives precedence to the data gathered ‘in practice’ over that gathered in interviews, treating the data from practice as closer to ‘theories-in-use’ – what people do – and from interviews as ‘espoused theories’ – what people say they do (Argyris and Schön, 1974). The other data are difficult to place in this distinction, because not enough information is known about how most of it was produced. As a result, this data is treated as relevant to practice in comparison to the other data that is more easily assigned to either of those categories. I.e. documents and reports are treated as more relevant to espoused theories if they reflect the data from interviews, and more relevant to theories-in-use if they reflect data from practice.

4.7.5 Validity

The notion of validity is important for all research; however, it is a concept that has ‘spilled over’ from quantitative traditions and so may not be wholly suitable for qualitative, engaged approaches (Klenke, 2014). Alternative measurements have been suggested such as ‘trustworthiness’ or ‘meaningfulness’ in relation to context (Klenke, 2014). Nevertheless, validity is relevant for this thesis in order to provide a guide to the reader and reassurance as to the quality of the research. The concept is generally separated into two types:

1) Internal validity – how reliable the research is as a representation of what it has researched.

2) External validity – how relevant the research is to other contexts; how replicable it is.

This research, taking a pragmatic approach, does not concern itself with external validity, outside of acknowledging the possibility that the findings could apply anywhere there are similar contexts. Generalizability could feasibly exist in any context, if the findings were found to be practically useful, but I am not claiming that they will be. The research does have some external validity due to its grounding in action and focus on whether participants actually do what they say they do. Eden and Huxham (1996) suggest such approaches allow generalizability through the use of knowledge gained by research participants in other situations they encounter; across other contexts and other participants who identify similar concerns; and through the development of knowledge within the
researcher and the application of that knowledge in other contexts that they may find themselves in. This is generalizability through the notion of legacy (Levin and Greenwood, 2001).

Internal validity in this research comes from two elements:

1) Thorough documentation of the research design - including reflexivity (Trussell, 2014) - so that a clear, consistent, and robust picture of the research context, process, and findings are available to the reader – essentially that the research ‘makes sense’ academically; and that the research achieves what it sets out to in relation to the principles from which it derives;

2) That the research findings make sense to participants and others within the context from which they were developed; that any recommendations/tools developed are practical and useful; and that participants view the research as having been a positive thing to been involved in. This fits more closely with Klenke’s (2014) alternative qualitative measures of ‘trustworthiness’ and ‘meaningfulness’ which rely on transparency, self-reflection on the part of the researcher, completeness, and the consideration of conflicting interpretations.

Greenwood and Levin (1998) offer an alternative notion of ‘credibility’ in research, foregrounding the link to practice, and suggest research is ‘internally credible’ when it is relevant and useful to participants, and ‘externally credible’ when it is enough to convince someone not involved with the research that the research is ‘believable’ (Greenwood and Levin, 1998).

It is important to note that engaged forms of research are difficult to do, can take many decades to master and that often the guidelines set out in the literature are not wholly achievable (Levin and Greenwood, 2001; Eden and Huxham, 1996; 2006; Coghlan and Brannick, 2010; Eden and Ackermann, 2018). As a result, the guidelines suggested in the literature around Action Research and Ethnography are used as ‘reflective pointers’ (Levin and Greenwood, 2001) rather than a test of validity themselves.
4.7.6 Sampling

The sampling for this research was purposive, i.e. I purposefully sought out a specific sample on which to carry out my research. Within that sample, and during the data collection itself, sampling was opportunistic and snowball-like, i.e. I gained access to meetings and events as I was able to find out about and negotiate access to them; I was able to interview participants based on connections I had made as I progressed through the research; and I was able to acquire documents and other materials as I encountered them or requested them upon hearing of their existence. Purposive sampling is aimed at theory construction rather than representativeness (Klenke, 2014).

4.7.7 Triangulation

The notion of triangulation in this research takes the concept from RO-AR in which, rather than referring to the use of mixed methods to create different sets of data that are then compared to each other, aims to create more robust findings by “approaching the research question from as many different angles as possible and employing redundancy in data collection” (Eden and Huxham, 2006, p. 53). Triangulation in this sense uses different elements of data within the same data set, between:

- The OBSERVATION of events and social processes
- The ACCOUNTS each participant offers
- The changes in accounts and interpretations as TIME PASSES

Hence this research combines data collected through observations (field notes) plus interviews, conversations, and documents over the period of one year. The data from these three aspects are not expected to agree - it would be surprising if they did - the idea is to discover multiple views and open up the possibility of uncovering competing perspectives. Triangulation in this meaning therefore acts as an "effective dialectic for the generation of new concepts." (Eden and Huxham, 2006, p.537).

4.7.8 Researcher position

My general position within this research was one of a ‘friendly outsider’ (Greenwood and Levin, 1998) to the practice context. This is to say that I maintained a position that allowed me to ‘open up’ local
processes, instead of being a complete insider researcher, which would have necessitated researching
a practice I was already involved in and that I was committed to continuing to practice after the
research had come to an end (Coghlan and Brannick, 2010). In an ethnographic sense I was involved
in participant observation, but I was also an observant participant, at times switching between
comparative involvement and detachment (Hammersley and Atkinson, 1995). Adopting a ‘friendly
outsider’ position had some distinct advantages. In particular, maintaining a link to the academic
context allowed me the time to both reflect on my position and approach to research and time to
complete the necessary tasks for the completion of my PhD. In addition, my position as an ‘outsider’
was of benefit to me in the practice context, in the sense that I was able to intervene without the fear
of personal reprisal and ‘speak the locally unspeakable’ (Greenwood and Levin, 1998). I was able to
draw attention to the resources available to people outside of the local context that were beyond
their day-to-day considerations, particularly sources of additional information. I was also able to avoid
some of the issues that can result from becoming too close to a practice environment, such as coming
to embody the contradictions under investigation (Humphrey, 2007). The friendly outsider is a
potentially risky position for the researcher in that there is more emphasis on practitioners in the
local context accepting (or not) the position of the researcher, rather than the researcher being an
automatic participant in their own practice. In addition, Blaikie (2007) notes that adopting an
outsider, as opposed to an insider position can result in the researcher being aloof or separate from
the research context, particularly if it is combined with an approach focussing on the researcher as
‘expert’ rather than ‘learner’. As a result, I tended to adopt a co-learner position during the research.
The downside to this position is that arguably I was not totally immersed in the practice environment,
however, during all research, any researcher adopts many different roles in relation to the inside-
outside dynamic. This exists as one of many issues of identity that have to be navigated when
‘working the hyphens’ (Fine, 1998; Wagle and Cantaffa, 2008; Cunliffe and Karunanayake, 2013), "the
simultaneously linked and divided relational positioning of the researcher vis-à-vis 'respondents'" (Mauksch et al., 2017). As such, I at times did act as a complete insider in relation to certain elements
of the research while at others I was very much an outsider. This mainly related to the level of participation I had in different environments and included:

- **Complete Participation** – this involved taking part in the practice environment as if I was a non-researcher. This was often necessary in order to take part at all. For example, a workshop on emotional overeating required me to actually do the learning exercises that were being delivered. Although this had a huge advantage in terms of the knowledge of practice and links with other practitioners (not to mention the learning experience itself), it was at times difficult to create the space to capture research data and field notes were often hurried. I also felt some pressure to justify my involvement in sessions like this considering I was not going to apply the learning in the research context as others were.

- **Partial Participation** – this was a more ‘relaxed’ context in the sense that there was no outright pressure to be directly involved. Quite often these were meetings or consultations at which I was a facilitator, or group sessions in which I was an attendee – the key point being there was no expectation that I would contribute throughout but the opportunity to do so was there at different points. There was still a need to be engaged in what was happening as there was a possibility that a contribution would be needed at some point but there was far more space to collect data and make notes on what was happening.

- **Limited Participation** – these were mainly presentations and other events where there was very little audience interaction. There was the opportunity to ask questions or seek clarity and so a need to stay engaged with what was happening.

- **No Participation** – I was not able to attend some events so the ‘official’ records, along with the information given to me by others who were there was the only available data. I took the opportunity to analyse the official record of such events and to create data through conversations with practitioners about them, so such instances were not entirely lost opportunities.
Of final note in relation to position is that researchers don’t just negotiate the different positions at play separately but can embody several different positions at any one time (Trussell, 2014). This was certainly something that I experienced during this research. Trussell (2014) suggests reflexivity on the part of the researcher is essential for navigating such a situation.

4.8 Reflexivity

4.8.1 Theoretical Basis

“Reflexivity is an aspect of all social research” (Hammersley and Atkinson, 1995, p.22) and therefore understandably there are a variety of different approaches to the concept of reflexivity within the academic literature. However, most focus in some form on “the complex relationship between processes of knowledge production and the various contexts of such processes as well as the involvement of the knowledge producer” (Alvesson and Sköldberg, 2000, p.5). This essentially means that the process of research – particularly the empirical aspects – are problematised or questioned rather than taken for granted as representations of ‘truth’ or ‘reality’. However, that does not imply that any basis for knowledge is abandoned, rather it is important to maintain a commitment to generating insights from research contexts that can aid understanding. Alvesson and Sköldberg (2000) suggest that reflexivity in research has two basic characteristics: (1) Careful interpretation; and (2) reflection. The first highlights that all references to empirical data result from some form of interpretation, and that there can be no unequivocal link between empirical data and anything outside of it. The second characteristic brings the focus onto the researcher as a person and on the tradition in which they operate. It is applicable at several different levels and can be defined as “the interpretation of interpretation” (p.6).

Although in some ways the rise of reflexivity within research can be seen as a response to a ‘crisis of representation’ in the social sciences and rejection of positivism/post-positivism (Denzin and Lincoln, 2005a) it is also not a retreat into endless interpretations in a postmodern sense (Denzin, 1997). It is
in many ways a *pragmatic* answer to these two positions (Alvesson, 2002; Sellars, 2013). Despite this, reflexivity has been criticised for implying a certain “intellectual narcissism” (Bourdieu and Wacquant, 1992, p.68) on the part of the researcher. These criticisms have led to an alternative approach that attempts to look at the researcher as an objective element of the research, rather than a subjective one, one that can be analysed in the same way that other research elements can be (Bourdieu and Wacquant, 1992). This in turn has been criticised for implying a ‘subtle realist’ and structural approach that does not allow for change or innovation (Nicolini, 2012). Taking a Pragmatic approach to this research serves as an advantage as it allows for a reflexivity that can inform change and innovation, through a focus on practice (Pratt, 2016).

For the purposes of this research reflexivity is applied in line with the tradition of engaged research approaches, primarily Ethnography and Action Research. In ethnographic research for example, reflexivity is a response to the fundamental issue that social researchers are part of the research contexts that they study and that research does not take place in “some autonomous realm that is insulated from the wider society and from the particular biography of the researcher” (Hammersley and Atkinson, 1995, p.17). In Action Research traditions, reflexivity is the concept used to “explore and deal with the relationship between the researcher and the object of research” (Brannick and Coghlan, 2007, p. 61). Huang (2010) suggests reflexivity in this context is autobiographical and fundamentally about acknowledging the self in research. Eden and Huxham (1996) emphasise the need to reflect on observations, methodology, theory, and “personal notes [regarding] feelings about the research” (p.534) and that such reflexivity is a tool to improve the validity of engaged research approaches, particularly those that do not start with strong assumptions regarding outcomes.

Brannick and Coghlan (2007) distinguish two main forms of reflexivity:

1) Epistemic reflexivity – the focus on the researcher’s belief systems and analysis of any metatheoretical assumptions at play.

2) Methodological reflexivity – monitoring the impact of the researcher’s behaviour on the research setting as a result of doing the research.
They suggest that different research traditions encourage different kinds of reflexivity; a positivist approach would more than likely be dominated by a concern with methodological reflexivity, whereas practice-oriented approaches would be more concerned with epistemic reflexivity. Hermeneutic and postmodern approaches in comparison are said to have a ‘hyper’ reflexivity, which is the root of the criticism around narcissism identified above. This research takes an approach to reflexivity that considers both epistemic and methodological reflexivity but with a pragmatic grounding that prevents such narcissism (Alvesson, 2002). As such, reflexivity is a complement to systematic method and orderliness (Eden and Huxham, 2006) and helps to draw out understanding.

4.8.2 Reflexivity in Practice

For the purposes of this research I kept reflective notes, including thoughts, feelings, concerns, frustrations etc. in Microsoft Word and OneNote software. They were organised in the following way:

- **Unstructured reflections** - An ongoing, Informal space to write freeform reflections about the research – this was started during planning for the PhD. It was created as a space to be able to ‘dump’ thoughts and feelings about the research without the need for any particular structure. At times these notes were revisited in order to check for any pointers and inspirations that may have been missed from other sources. Very often the entries to this unstructured area were echoed in other, more structured reflections. Primarily, these reflections were ‘epistemic’, however, due to their unstructured nature they also contained some ‘methodological’ elements. As might be expected, these notes were very general to begin with and became more specific as the research progressed.

- **Reflections ‘in the field’** – these reflections were more formal and gathered alongside the data collection process. They were primarily ‘methodological’ – concerned with my impact as

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2 To some extent this was also restricted by the nature of the research itself, being for the reward of a PhD. It would be difficult within the final thesis to question the value of research that is was carried out specifically in order to lead to the production of a thesis, although at times I certainly engaged in such reflections!
a researcher on the research environment. These were created in order to generate insights into the research process and potential findings. I took the decision to separate these reflections into several categories: ‘emotional’, ‘methodological’, and ‘general’, to give structure to what I was reflecting on in my own practice. These categories also fit with Eden and Huxham’s (1996) recommendations regarding what to reflect on during research.

- **Emotional reflections** – As noted in the Axiology section above (Section 4.4), the emotional aspects of ‘doing’ research tend to be neglected in research accounts (Clarke et al., 2015), particularly in relation to researching ‘where you’re from’ (Maile, 2015). I was acutely aware of my emotional links to the research and by extension the need to reflect on them. Equally, I was aware of the ‘false dichotomies’ (Maile, 2015) between subjective and objective that can exist in research and wanted to use reflections on my emotions to emphasize my own situated subjectivity in order to bridge this gap. On a more practical basis - and linking with the methodological reflections below – tracking the emotional aspects of research allowed me to keep track of my own wellbeing. For example, I was able to build in time to take a break from data collection when I identified my emotional reflections had become consistently more negative. I kept these reflections separate from others in order to maintain a focus on emotional aspects and to aid processing and recall, however, often emotional reflections were mixed in with other elements and so there was an amount of overlap across the different categories. These reflections were typed into a Microsoft Word document, often from handwritten notes that had been created in the research context.

- **Methodological reflections** – These reflections aligned to some extent with Brannick and Coghlan’s (2007) definition of ‘methodological’ reflection, in that they were partially an attempt to track my influence on the research context. These reflections also captured how the research was progressing, including: concerns; potential changes (to data collection or interventions for example); ongoing ethical considerations (such as how to deal with participants revealing personal information); and the changing face of the research context.
(project changes, participants moving jobs etc.). These reflections attempted to capture the iterative nature of inquiry, and some of the thought processes involved in the decisions that I made. These notes were often created away from the research context, after time to consider the issues involved. The notes were typed into Microsoft Word.

- **General reflections** – This category of reflections was created to capture anything related to the ongoing fieldwork that did not fit into the two other categories. It was very similar to the ‘unstructured reflections’ in its content but, because it formed part of the data collection phase specifically, was more structured, was cross-referenced with the other sections, and had a chronological order. This category captured such considerations as: potential links with theoretical areas; observations about the specific work/interventions that I took part in as a researcher; developing themes; the roles of different people and organizations, etc. Again, there was a large amount of overlap between this category and the others, as well as the field notes that formed the majority of the data for this research. These were also typed up in Microsoft Word.

All of these categories of reflections *in the field* were ‘structured’ in the sense that each reflection had a date attached to it and they were arranged in chronological order. This was done with the understanding that the reflections themselves were potentially part of the data produced in the context of the research. These structured reflections were imported into Nvivo and used to inform Phases 4 and 5 of analysis (reviewing and finalizing themes); however, they were not treated as data themselves and so did not form part of the coding process. Chapter 5 – Analysis goes into greater detail about the phases of analysis.

Initially, my reflections were made up of feelings, notions, or thoughts that developed from ‘doing’ the research and they came out of the context itself, informed by my experience and interactions with participants. There was no real strategy involved. However, as my fieldwork progressed, I became aware of a need to ensure I was doing justice to both my ability to collect robust and detailed data and the need to ensure my reflections were not just narcissistic. I also felt the need to apply the
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lens I had been using to consider my participants’ practice – that their theories-in-use often did not fit their espoused theories (Argyris and Schön, 1974) – to my own practice. Schön (1983) provides guidance to practitioners on how to develop reflective ways of thinking, and therefore acting, through ‘reflection-in-action’ and ‘reflection-on-action’. This approach has established links with engaged research methodologies (Eden and Huxham, 1996) and approaches that seek to combine Action Research and Ethnography in particular (Bath, 2009).

Reflection-in-action is thinking about what you are doing, sometimes even in the process of doing it. As Schön (1983) puts it:

"There is some puzzling, or troubling, or interesting phenomenon with which the individual is trying to deal. As he tries to make sense of it, he also reflects on the understandings which have been implicit in his action, understandings which he surfaces, criticizes, restructures, and embodies in further action." (p.50).

Much reflection-in-action depends on ‘surprise’ in practice as it is that that makes us consider how to respond. It’s important to emphasize that reflection-in-action takes place, as the name suggests, in action. Reflection-on-action, on the other hand, has more in common with general notions of reflection as it takes place outside the practice itself:

“Sometimes, in the relative tranquillity of a post-mortem, [practitioners] think back on a project they have undertaken, a situation they have lived through, and they explore the understandings they have brought to their handling of the case. They may do this in a mood of idle speculation, or in a deliberate effort to prepare themselves for future cases.” (Schön, 1983, p.61).

Capturing both reflection-in-action ‘in the moment’ and then later using reflection-on-action to consider more general aspects can be a useful way to anchor reflections in practice, rather than in the subjectivity of the researcher. Trussell (2014) describes a similar process to this in noting their use of ‘Epiphany Moments’ – when we become acutely aware of our own social positioning in the context of the research, relating to power, vulnerability, conflict, awkwardness, etc. and the ‘Cringe Continuum’ – the way in which different research activities, in which we occupy different positions, evoke self-conscious feelings of shame, embarrassment, shyness etc. These elements, rather than being a
negative aspect of research that attempts to keep ‘pure’ and free from personal/emotional contamination, are the building blocks of reflexive practice.

Using reflexivity in this way allowed me to ‘interrogate my interrogations’ by checking if what I was recording, and noting, was capturing what I set out to; whether my interpretations demonstrated any particular (unjustified) tendencies – such as undue influence from research participants; and whether I was drawing conclusions in my mind that were not supported by data. This was an interplay between the data that I was collecting and my reflexive notes and had some notable benefits, such as surfacing that I was capturing a lot of data on what was happening in practice but not as much on how things were happening. This realisation then refocussed my data collection. Further, I was able to actively identify and confront some of my axiological motivations within the research, namely, my positive inclination towards the voluntary sector. In doing so I realised I needed to work to maintain a critical approach. When the data revealed some negative elements of the voluntary sector, I was able to examine my reflections to interrogate whether I could represent the data in as accurate a way as possible.

Finally, it is important to say that being reflexive and thinking reflexively is a skill that develops over time; practitioners get better at it the more they use it (Schön, 1983). However, that is not to say that early attempts at being reflexive, such as in this research, do not have any value to the research itself. There may be aspects to build on in terms of my skill as a researcher but what I have done in this particular project has both benefitted my own development and added value to the research. This is an ‘attempt’ to ‘do’ reflexivity, rather than a claim for how it ‘should’ be done.

4.9 Summary of Research Design Chapter

In summary, this section has concentrated in detail on Research Design, including the pragmatic ontological and epistemological basis adopted and the focus on practice that was a fundamental part of it. The research adopted an engaged approach influenced by Action Research and Ethnography and included active participation and intervention by me as both researcher and participant. Because of
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the different roles I assumed at different times during the research it was important to include a strong reflexive element throughout the research process, in order to consider my own axiological influences and to interrogate my interrogations.

The chapter also detailed the methodological approach taken and the open approach to data collection in which a wide range of different data were collected for analysis. Because of the focus on practice, precedence was given to the data that captured what participants actually did, as opposed to what they said. Validity and generalisability were discussed, and the case was made that even highly contextual research can contribute to wider understanding.

The following section describes the approach taken to analysis of the data gathered through the design process outlined above.
Chapter 5. Analysis

5.1 Introduction to Chapter 5

The analysis in this research was closely informed by approaches to ‘thematic analysis’ detailed by Braun and Clarke (2006) and Gioia et al. (2012). It is inductive, in that it aims to produce insight from the data itself, rather than through theory testing (Blaikie, 2007). Inductive analysis is particularly suited to questions that seek to establish ‘what?’ is happening in a given situation and that seek to provide detailed descriptions of particular contexts. Thematic Analysis (TA) is the most commonly used method of analysis in qualitative research (Guest et al., 2012) and as such has been applied in a variety of different ways, to the extent that there is no one singular identifiable approach to the method and no specific guidelines in how to carry it out (Bryman, 2008). Braun and Clarke (2006) suggest that one of the reasons for the popularity of TA is that it is very flexible as a method and can be applied to a variety of different types of data, in different research areas. Equally, TA can be applied within very different ontological and epistemological assumptions (Robson, 2011).

Thematic analysis is seen as being particularly useful in “capturing the complexities of meaning within a textual data set” (Guest et al., 2012, p.11) and in allowing the integration of different types of data, particularly field notes and interview transcripts (Strom and Fagermoen, 2012), which form the bulk of the data in my research. The flexibility of TA is also seen as offering the opportunity for different forms of theorising, away from the potentially constricting processes advocated by other approaches to analysis (Gioia et al., 2012). It is a method of identifying patterns in data and organising that data within context, enabling the ‘thick description’ and rich detail to be retained. It is an accessible form of analysis which also allows for – and actually requires (Guest et al., 2012) - the active role and involvement of the researcher as themes don’t just ‘appear’ but are actively selected (Braun and Clarke, 2006) and the researcher is ‘implicated’ throughout the process of generating data (Irwin and Winterton, 2012). This foregrounding fits with the active role of the researcher within engaged
methodologies such as Action Research and Ethnography. TA is also a pragmatic approach in that it is a good ‘tool for the job’. Specifically, its accessibility means it can be used without any additional training or skill development; it allows for the combination of different types of data in a consistent way, and it allows for the efficient analysis of a large amount of data. The flexibility of TA can make its use opaque unless care is taken to detail the specific steps taken. The aim of this chapter is to provide a clear description of the strategic and rigorous approach to analysis adopted, and how that was applied in order to analyse the complex data collected. To do so I will first consider the theoretical grounding of TA before showing in detail how I applied this theory in practice. Adopting this approach to analysis requires researcher reflexivity in order to navigate the complexities involved - much in the same way reflexivity is required during data collection - and so I will detail the approach taken to this. Detailing the reflexive approach can - along with other aspects - help to detail the quality of analysis, and so a section of the chapter is devoted to my approach to ensuring quality. Finally, I will provide a brief overview of the themes that developed through enacting this approach as a link into Chapter 6 – Findings.

5.2 Analytical Approach – Theoretical Grounding

The approach to analysis in this research is particularly informed by Braun and Clarke (2006) and it broadly follows their ‘six phases of thematic analysis’ (see Table 5-1 below – p.140). However, as noted above, Thematic Analysis is very flexible and as such these phases were adapted as analysis progressed.
**Table 5-1 - The Six Phases of Thematic Analysis**

<table>
<thead>
<tr>
<th>Phase</th>
<th>Description of the Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Familiarising yourself with your data</td>
<td>Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.</td>
</tr>
<tr>
<td>Generating initial codes</td>
<td>Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.</td>
</tr>
<tr>
<td>Searching for themes</td>
<td>Collating codes into potential themes, gathering all data relevant to each potential theme.</td>
</tr>
<tr>
<td>Reviewing themes</td>
<td>Checking that the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic 'map' of the analysis.</td>
</tr>
<tr>
<td>Defining and naming themes</td>
<td>Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells; generating clear definitions and names for each theme.</td>
</tr>
<tr>
<td>Producing the report</td>
<td>The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of select ed extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.</td>
</tr>
</tbody>
</table>

(Source: Adapted from Braun and Clarke, 2006. p.35)

Key within each of these phases is the need to be reflexive; to move back and forth between the data and the themes generated. This crucially involves writing about themes and codes as they are generated, either in a reflective journal, ‘jottings’, or in ‘memos’ (Miles et al., 2014). ‘Jottings’ “can strengthen coding by pointing to deeper underlying issues that deserve analytic attention” (Miles et al., 2014, p. 94), while a ‘memo’ is “a brief or extended narrative that documents the researcher's reflections and thinking processes about the data. These are not just descriptive summaries of data but attempts to synthesize them into higher level analytic meanings." (Miles et al., 2014, p.95). In addition, as analysis isn’t linear, writing about the process – as opposed to just the outcomes – of analysis allows for a path to be tracked through the data in a structured and progressive way. As Thematic Analysis is an approach that allows for a great deal of flexibility around analysis, and adaption to the needs of specific research and researchers, the way these phases were used in this research differed slightly to that detailed in Table 5-1 (p.140). Section 5.3 explores the approach in practice.
Chapter 5 Analysis

Bryman (2008) suggests that Thematic Analysis is usually organised around a ‘matrix’ approach to organising data. This involves the presentation of different themes within the data in a table or tables, alongside the specific examples or ‘chunks’ from the data relevant to that theme. This allows for a clear link between the data and what has been developed from them. It also allows for the direct use of participants’ own words in the construction of theoretical contributions and a link to practice. TA also allows for the combination of findings from different types of data, including the two main types of empirical materials used in qualitative research (Perakyla, 2005) – interviews and naturally occurring materials – that form the basis of data for my research. In this way, different categories of data can be brought together as an analytical whole (Strom and Fagermoen, 2012).

The analysis adopted in my research was also informed by the work of Miles and Huberman (1994; Miles et al., 2014) and their detailed approach to qualitative analysis. They suggest their approach can be used across different research methodologies and philosophies in a ‘pragmatic’ sense, however, they also offer a very deliberate and ordered structure within this. They highlight the close fit between their approach to analysis and both ethnographic and grounded theory research approaches.

The above six phases neatly describe the general processes that are undertaken by researchers when examining qualitative data in an inductive way. The next section will detail how I implemented these phases in practice.

5.3 Analytical Approach in Practice

The flexibility of TA as an analytical approach allows for its adaptation to a variety of different research contexts. Gioia et al. (2012) suggest strictly following a given or traditional approach that is rooted in what we already know can limit what we can potentially know. With this in mind, although my research broadly followed Braun and Clarke’s (2006) ‘Six phases’ of thematic analysis, there were some departures and deviations in order to fit the needs of the research. In this section I will explore each phase in turn. It should be highlighted that these stages were not mutually exclusive and so
were not always followed in a hierarchical order – for example, some of the themes emerged during the ‘familiarisation’ phase rather than in phase 3. Figure 5.1 below (p.142) shows how the six phases were used during analysis.

**Figure 5.1 - Phases of Thematic Analysis in Practice**

**PHASE 1 — Familiarisation**
- Begins during data collection
- Ongoing
- Emergence in context
- Processing data

**PHASE 2 — Generating initial codes**
- Using NVivo
- Line by line
- Being reflexive
- Large amount of codes

**PHASE 3 — Searching for themes**
- Consolidating
- What was there; what was missing
- Displays and narratives

**PHASE 4 — Reviewing themes**
- Selecting the focus
- Linking themes
- ‘Making sense’

**PHASE 5 — Defining and naming themes**
- Building on Phase 3 narratives
- Feedback from participants

**PHASE 6 — Producing the report**
- Ongoing revision of themes
- Drafting
- Thick Description

(Source: created by author based on process of analysis adopted)
Chapter 5 Analysis

The detail of each phase of analysis was as follows:

5.3.1 **Phase 1 – Familiarising Yourself with Your Data**

Familiarisation is achieved through repeat reading of data, through transcription (if that is required) and through summarising or organising data in preparation for later analysis. It is an opportunity to note down any initial ideas or what ‘jumps out’ in terms of emerging concepts (Miles and Huberman, 1994; Braun and Clarke, 2006). Familiarisation actually starts during data collection (Gioia et al., 2012) as part of the “dialectical interaction between data collection and data analysis” (Hammersley and Atkinson, 1995, p. 205). Engaged research over time requires that any research approach is adapted in an iterative way in order to fit more appropriately to the specific characteristics of the particular context. The role of reflexivity within engaged research also requires reflections on data in order to feed into both formal analysis and further data collection. Examples of such analysis via reflection within this particular research are the unstructured reflections kept as a form of research diary, and the more formal, structured reflections on participant observation/observant participation.

Within this research, each day of data collection was typed up in Microsoft Word before being transferred into NVivo for coding, and I also transcribed each interview myself. This meant that the data had been initially recorded/written, reflected upon, transcribed/typed up, organised, and then transferred into NVivo; as a result, familiarisation with the data was very high before the formal coding process began. **Figure 5.2** below (p.144) shows the stages of processing data. This formed part of the “qualitative analytic attitude” (Silverman, 2011, p. 64) adopted within this research – a pragmatic, hands-on, tacit knowledge of analysis through an absorption in the context from which data is drawn. Inevitably, this also resulted in the development of initial themes within the data that then informed further data collection and were either built upon, discarded, or revisited during the formal coding process, starting with Phase 2.
**Chapter 5 Analysis**

**Figure 5.2 - Stages of Processing Data**

Original Field Notes (black squares hide sensitive information)

![Original Field Notes]

Typed up into Microsoft Word

![Typed up into Microsoft Word]

Then Imported into NVivo for Coding

![Then Imported into NVivo for Coding]

(Source: created by author based on original field notes, Word file and Nvivo analysis)
Chapter 5 Analysis

5.3.2 Phase 2 - Generating Initial Codes

The method of generating initial codes in this research is largely informed by the work of Miles and Huberman (1984; also, Miles et al., 2014) who provide a large amount of detail in relation to the process of qualitative data analysis. Following on from the familiarisation phase, the initial coding phase involved attaching descriptive, evocative or complex definitions and summaries (codes) to ‘chunks’ of the data. Gioia et al., (2012) define this as ‘1st order’ analysis – i.e. it is the first attempt at ‘ordering’ the data. Codes were attached to a variety of different ‘chunks’ whether they were single words; whole sentences or paragraphs; or even to entire documents. The coding was carried out using the NVivo software programme, which classifies these chunks of data as ‘nodes’. Figure 5.3 below (p.145) shows an example of this coding in NVivo, the different chunks of text are highlighted in the central pane, with the attached nodes showing vertically on the right-hand side. An initial test of this coding process was carried out on a small subset of the data in order to increase familiarity with the software and with the process of generating the nodes from the data before embarking on the analysis of the full dataset.

*Figure 5.3 - Coding in NVivo*

(Source: created by author based on Nvivo analysis)
This analysis was inductive in the sense that no framework was used to guide the analysis and the codes were generated from the data. The majority of the coding carried out at this stage was of the ‘descriptive’ sort – assigning a code to data as a label in order to summarize a point of interest, topic, concept etc. (Miles et al., 2014). As each new code was identified in the data a new ‘node’ was created in NVivo, a description was given to each node in order to make it easier to identify, to detail what was meant by often abstract labels, and to prevent overlap/duplication between nodes. The existing list of codes was reviewed for any nodes that were similar. As the analysis progressed, some nodes were changed to fit with the picture that was developing, and others were ‘added to’ as supporting information was identified. This was tracked using the ‘memo’ feature in NVivo. Each entry into a memo has a date attached so the progress of analysis can be viewed chronologically. In addition, potential theme ideas were captured at this stage with the use of other memos – these were short notes with the title of a potential theme and a description of how that theme related to the data. Memos were also used to cross reference different nodes and potential themes and give reminders and tips as to how they could fit together. Figure 5.4 below (p.147) is an example of how these memos were used, in this case for the development of the ‘link to community’ node.
Familiarisation with the data at different stages meant that there were some judgements made about potential codes and themes at different phases. This is a fundamental part of the research process and is in line with the recommended approaches of engaged research. The recording of reflections throughout data collection and analysis meant that it was possible to identify where ideas and influences came from as the analysis progressed. In addition, ‘familiarisation’ is an analytical phase itself and so therefore is not distinct or detached from the process of analysis.

As mentioned previously, the process of analysis is often not a smooth or straightforward one and, in my research, there was a constant movement between the data, analysis of that data, reflections, and research questions throughout the analytical process. Both during the familiarisation phase and the initial coding, the focus was on what ‘jumped out’ (Miles and Huberman, 1994) from the data, both in terms of what ‘was there’ and what ‘wasn’t there’. This follows Braun and Clarke’s (2006) definition of the process of coding which suggests "codes identify a feature of the data (semantic content or latent) that appears interesting to
the analyst” (pg.18, italics added). In this sense the subjectivity of the analyst is acknowledged and foregrounded.

Initial coding is time consuming and can be tedious. Enacting this approach to analysis in practice involved both going through the data line by line and carefully reading what was found whilst also taking a more holistic view of data sources in order to capture the general points that a focus on the minutiae can miss. Often, initial coding can generate a huge number of codes/nodes and this can feel overwhelming to the researcher or create a sense of feeling of being ‘lost’ (Gioia et al., 2012). My research generated 372 nodes in NVivo with over ten thousand references (a ‘reference’ is an instance of a node being applied to a selection of data) which certainly at times felt confusing! Having such a large number of nodes is also not particularly useful analytically in terms of ‘making sense’ of the data or communicating research findings. However, these initial codes are the building blocks of the thematic analysis process that are then used to construct the later stages. Specific attempts were made to capture contradictory and conflicting data through the use of ‘positive’ and ‘negative’ nodes, reflecting both sides of potential themes, and in searching for opposites or outliers.

5.3.3 Phase 3 - Searching for Themes

Once all of the data were coded the next stage involved searching the codes for potential consistencies in order to develop ‘themes’. Robson (2011) describes this as sorting the multitude of codes from Phase 2 into ‘coherent patterns’. After the fragmentation that occurs during the initial coding, this stage is about condensing the data in order to make it stronger; “data condensation is a form of analysis that sharpens, sorts, and organizes data in such a way that ‘final’ conclusions can be drawn and verified” (Miles et al., 2014, p.12). In this research this stage involved:

- Building new codes by consolidating several initial codes into one, either an existing node (mostly for where duplication had occurred) or new nodes that captured consistencies
within the smaller nodes. This included looking for repetitions, metaphors, similarities and differences, missing data, contradictions, relationships (between people, organisations, things), causes/explanations, patterns etc. The process was carried out within the NVivo software itself where it was easy to create new nodes and move existing nodes into them. NVivo was also helpful as it showed the number of times a node had been used; although this research was not quantitative, these numbers acted as something of a guide, directing the search for themes towards those codes that were most present within the data. This was very much a starting point however as some codes with very little presence in the data had large impacts on the practice environment, were able to be linked together to form more substantial themes, and at times provided contradictory evidence against the overarching consistencies of nodes with greater numbers of references. One of the dangers of inductive analysis in this way is that the data itself may not accurately reflect the experience of practice, i.e. something may happen in practice on one occasion – a conflict between people or organisations for example – that has a massive impact on the context in question (arguably the more significant the instance, the less likely it is to reoccur) but the rest of the time there may be very little conflict. An inductive analysis of the data might conclude that there was very little conflict within the context in question and move forward under that assumption. Having been ‘in the field’ for 12 months and experienced the practical consequences of the data in question, I was able to act as a meaning maker, interpreting the significance of the data beyond its constituent parts, and noting where the data itself does not show something that was present in practice that may have been unsaid or unexplored but that was revealed through my reflexivity. With this in mind, it was important within the research not to be too directed by the numbers of references of nodes and remain reflexive as to what the presence or absence of data might mean.
- **Using ‘displays’ to summarise content** – this involved the use of ‘matrices’ (Miles and Huberman, 1994) in Microsoft Excel. Coded chunks of data were exported from NVivo into Excel in order to develop an overall picture of the data for each developing theme. This process helps to order the data and to present a view of it that is more accessible and easier to process than the ‘extended text’ of the initial data which “overloads our information-processing capabilities and preys on our tendencies to find simplifying patterns.” (Miles et al., 2014, p.13). Matrices were created for a variety of different codes and some were created as consolidations of several codes. **Figure 5.5 below** (p.150) shows a section of the ‘Leadership’ matrix display in Excel.

*Figure 5.5 - Excel Leadership Matrix Display*

![Excel Leadership Matrix Display](image)

(Source: created by author from Excel file)

Displaying the data in this way also allowed for repetitions and duplications to be observed, and for important ‘chunks’ of information to be identified that could then be examined further. This was done through the process itself, for example, if a quotation or passage of text was entered into several of the matrices it highlighted that it was an important element of the data; despite the fact it might it may not have been a significant
enough aspect to have its own theme the relevance of that instance to several different themes hints at something important having happened or having been expressed. Further analysis could then take place as to why this was the case. This importantly included whether the data was robust enough to be included on its own or whether further examples were needed in order to justify findings. Another practical benefit of this was that it drew out specific chunks of data that could then be copied into the final report. Other displays were developed at this stage, including initial drafts of some of the diagrams and tables that would go on to be included in this thesis. These were created both within NVivo itself and with Microsoft Word and Publisher. They aided analysis by providing alternative opportunities to structure the data and develop understanding, as well as a challenge in presenting findings in a way that ‘made sense’ together and in relation to the whole dataset.

- **Narratives were also written for each of these matrices.** This was principally to see if the matrices ‘made sense’ when typed up in a form similar to how they would be presented in the final thesis, and also to see which elements linked together to form a potential overarching story of the data. It also allowed for the data to be recontextualised and therefore the opportunity to reflect on whether each emerging theme ‘made sense’ in light of the overall context. Writing these narrative summaries also served the purpose of increasing familiarisation with the data and helped to identify where emerging themes could benefit from augmentation with additional examples from the data or where there were gaps in ‘the story’. Creating these narratives maintained a focus on ‘thick description’ in analysis and presentation of findings by linking analysis back to practice in context.

The fragmentation or ‘fracturing’ (Birks and Mils, 2011) of data during coding can be a criticism of approaches like Thematic Analysis, particularly when using software (Bryman, 2008) – separating the data out into ‘chunks’ removes it from context – so
the narratives were used as a way to recontextualise emerging themes. These narratives were most often written at the same time, or shortly after the creation of the data matrices so as to maintain as much of the context as possible and not be driven wholly by the chunks of the data in the limited display field of the matrices.

As noted in Phase 2, memos were kept in NVivo in relation to the initial coding that fed into the development of themes. These node memos were ‘theme ideas’ that provided the spark for the creation of more substantial themes from the data. Memos were also kept in relation to potential themes and as the generation of these themes progressed the memos were added to in order to track theme development. These theme memos also included notes about links with similar themes and the rationale for decisions made in relation to naming and organising of them.

To summarise Phase 3, themes began to be developed by: (1) creating new codes through consolidating smaller codes into larger codes, and creating new codes from a consolidation of smaller codes; (2) extracting data from NVivo and importing into Excel to develop matrices to display the data in a more accessible way; (3) recontextualising the data and attempting to create a coherent picture of analysis through writing narratives based on these matrices. Memos helped to track the development of themes from nodes and provided space to show a rationale regarding theme development.

5.3.4 Phase 4 - Reviewing Themes

In practice, there was no distinct separation between phases three, four, and five. The review of themes was ongoing as a general part of both initial coding and theme development. The main reason for reviewing themes is to relate what has been developed back to the data, context, and goals of the research. Having carried out the previous stages of analysis and consolidated many of the codes in the ways identified above, there still existed a large amount of possible areas to explore in relation to the research. A pragmatic decision was necessary in order to focus on a limited number of
themes to include in the final report. This decision was based on the research questions which had been developing iteratively throughout the research process (see Section 4.7.1). This was combined with what ‘jumped out’ from the ongoing thematic analysis and which themes fitted together in order to tell a coherent story in relation to the research context and to ‘make sense’ in relation to the data as a whole. This was inspired in part by the ‘constant comparison’ of Grounded Theory, in particular, the notion of ‘anecdotal comparison’, which involves the use of personal knowledge and learning about an area as ‘principal insights’ into data analysis (Glaser and Strauss, 1967).

Simons (2009) suggests that data “do not speak for themselves” (p. 118) and that any interpretation must start from a holistic grasp of the data. The familiarity I had with the data and my knowledge of practice were a distinct advantage in relation to this. In addition, I adopted an approach that moved between a focus on specific data to an overall view of the dataset (and vice versa) as analysis progressed in order to check consistency and ‘make sense’ of the analytical process. This was informed by Nicolini’s (2012) concept of ‘zooming in’ and ‘zooming out’ which although introduced as part of a toolkit for practice research methodology, is equally useful as a metaphor for data analysis. In this sense, the ‘zooming in’ refers to the work on specific codes and themes, and the ‘zooming out’ refers to fitting those codes and themes into the overall picture of the research context, and how they link with others. Although the quantitative aspect of the coding process described above was useful in order to identify what had been coded the most in the data and therefore what areas might be important to follow up I was careful to use my discretion in this aspect as the nodes created in NVivo related to both general and specific aspects. For example, one node that was used heavily was ‘VS’ – to denote something relevant to the voluntary sector – however, this node did not provide enough context alone for any themes to develop from it. What it did do was provide an easy access point to all of the relevant data that referred to the voluntary sector which then aided the analysis of certain other nodes when cross-referenced using a ‘Matrix Coding Query’ – see Figure 5.6 on p. 154.

I made the decision in relation to what nodes to focus on and which themes to develop based on three things: (1) what had been coded the most in previous phases (with the above caveats), filtered
through: (2) what ‘jumped out’ from the analytical process (captured in NVivo memos), which in turn was related to what had ‘jumped out’ from the data; (3) what ‘made sense’ when telling the story of the data – which themes fitted together into a coherent narrative, whether they reflected a coherent picture of the data as a whole, and whether they conformed with what my experience had been in practice, including what had been expressed by participants.

**Figure 5.6 - Example of Matrix Coding Query**

![Matrix Coding Query](image)

<table>
<thead>
<tr>
<th></th>
<th>A: PS</th>
<th>B: VS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Constrictive Focus</td>
<td>158</td>
</tr>
<tr>
<td>2</td>
<td>Accountability</td>
<td>6</td>
</tr>
<tr>
<td>3</td>
<td>Closed process</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>Competition</td>
<td>1</td>
</tr>
<tr>
<td>5</td>
<td>Complexity</td>
<td>13</td>
</tr>
<tr>
<td>6</td>
<td>Concerns</td>
<td>12</td>
</tr>
<tr>
<td>7</td>
<td>Confusion - Uncertainty</td>
<td>13</td>
</tr>
<tr>
<td>8</td>
<td>Instability</td>
<td>2</td>
</tr>
<tr>
<td>9</td>
<td>Paralyzing</td>
<td>0</td>
</tr>
<tr>
<td>10</td>
<td>Contradiction</td>
<td>24</td>
</tr>
<tr>
<td>11</td>
<td>Duplication</td>
<td>9</td>
</tr>
<tr>
<td>12</td>
<td>Formal</td>
<td>3</td>
</tr>
<tr>
<td>13</td>
<td>Fragmented</td>
<td>12</td>
</tr>
<tr>
<td>14</td>
<td>Frustration</td>
<td>16</td>
</tr>
<tr>
<td>15</td>
<td>Hierarchy</td>
<td>19</td>
</tr>
<tr>
<td>16</td>
<td>Bureaucracy</td>
<td>0</td>
</tr>
</tbody>
</table>

**PS = Public Sector**  
**VS = Voluntary Sector**  
(Source: created by author from Nvivo coding query)

### 5.3.5 Phase 5 - Defining and Naming Themes

As mentioned above, Phase 5 was not distinct from Phase 4 as the work to define and name themes was an ongoing task. The formal elements of this included gathering feedback from participants on two occasions during visits back to ‘the field’, and from academic supervisors in relation to whether the chosen themes ‘made sense’. Much of the work towards this was carried out in Phase 3 with the writing of narratives for each of the theme matrices, and the comparison of these back to the data as a whole and to the research context. The final themes were made up of a broad range of cross-cutting subthemes and nodes. **Table 5-2** on p. 155 is a partial representation of the themes at this stage with the subthemes and nodes that fed into them.
Table 5-2 - Partial Representation of Phase 5 Themes and Sub-themes

<table>
<thead>
<tr>
<th>The Role of the Voluntary Sector in WE</th>
<th>Trust, Power, and Control in WE</th>
<th>Leadership</th>
</tr>
</thead>
<tbody>
<tr>
<td>VS Profile in WE</td>
<td>Trust</td>
<td>The Right People</td>
</tr>
<tr>
<td>WE Profile in VS</td>
<td>Power</td>
<td>Longevity</td>
</tr>
<tr>
<td>VS Practice – Ways of Working</td>
<td>Control</td>
<td>Profile</td>
</tr>
<tr>
<td>VS Constrictive Focus</td>
<td>Top-down control</td>
<td>EMLA</td>
</tr>
<tr>
<td>VS Emancipative Focus</td>
<td>Bottom-up control</td>
<td>Followers</td>
</tr>
<tr>
<td>PS-PS</td>
<td>Middle-down control</td>
<td>Personal Relationships</td>
</tr>
<tr>
<td>Individual Versus Community</td>
<td>Middle-up control</td>
<td>Common Ground</td>
</tr>
<tr>
<td>VS and Funding</td>
<td>WE</td>
<td>Understanding</td>
</tr>
<tr>
<td>Evidence – Data</td>
<td>WE Brand</td>
<td>Respect</td>
</tr>
<tr>
<td>WE Sustainability</td>
<td>WE Culture</td>
<td>Exhausting</td>
</tr>
<tr>
<td>EVA</td>
<td>WE Goals and Aims</td>
<td>Personal Skills</td>
</tr>
<tr>
<td></td>
<td>WE Ownership</td>
<td>History</td>
</tr>
<tr>
<td>EVA as VS in WE</td>
<td>VS Forums</td>
<td>Individuals</td>
</tr>
<tr>
<td>EVA Profile</td>
<td>Organisational Relationships</td>
<td>Staff Relations</td>
</tr>
<tr>
<td>Representing the Sector</td>
<td>Constrictive Focus</td>
<td>Staff Sameness</td>
</tr>
<tr>
<td>EVA as WE</td>
<td>Pressure</td>
<td>Staff Difference</td>
</tr>
<tr>
<td>EVA Boundaries</td>
<td>Hierarchy</td>
<td>Staff Multiple Identity</td>
</tr>
<tr>
<td>Link to Community</td>
<td>Frustration</td>
<td>Staff Turnover</td>
</tr>
<tr>
<td>Engagement</td>
<td>Accountability</td>
<td>Capacity</td>
</tr>
<tr>
<td>Individual</td>
<td>Risk</td>
<td>Change</td>
</tr>
<tr>
<td>Person-Centred</td>
<td>Contradiction</td>
<td>Doing Things Differently</td>
</tr>
<tr>
<td>Co-production</td>
<td>Emancipative Focus</td>
<td>Being Stuck</td>
</tr>
<tr>
<td>Asset-based</td>
<td>Sharing Information</td>
<td>Culture</td>
</tr>
<tr>
<td>Forceful</td>
<td>Informal</td>
<td>Not Being Brave Enough</td>
</tr>
<tr>
<td>Community as Community Groups</td>
<td>Autonomy</td>
<td>Simplification</td>
</tr>
<tr>
<td>Inputs to Community</td>
<td>Sharing Practice</td>
<td>Values</td>
</tr>
<tr>
<td>Participation</td>
<td>Increased Understanding</td>
<td>The System</td>
</tr>
</tbody>
</table>

(Source: created by author based on themes developed during analysis in Nvivo and Excel)
5.3.6 Phase 6 - Producing the Report

The final themes continued to be revised throughout the thesis writing period. Revisions became less significant as the phases progressed so that, by Phase 6, any changes were small. The coherence of the overall narrative came into play at this stage in a critical sense as each theme’s final form developed, it also became more pressing at this stage to link the findings to specific literature that could explain the practice in question – this is important as there had been a ‘willing suspension of belief’ (Gioia et al., 2012) during earlier stages of analysis in terms of links to previous literature. It is important to note that this ‘suspension of belief’ is not a suggestion that I was able to adopt some sort of totally objective, detached position in relation to the research. On the contrary, my research sides with the view that “no [researcher] can possibly erase from his mind all the theory he knows before he begins his research.” (Glaser and Strauss, 1967, pg.253). However, no specific or individual theory drove this analysis.

The overall focus of the analysis was to develop a ‘thick description’ (Geertz, 2005/1972) of the practice context. This initially resulted in something of a ‘messy text’ (Denzin, 1997) that moved between description, interpretation, and voice. Although Denzin (1997) suggests such ‘messy texts’ should be the goal of engaged research approaches, my messy text was refined somewhat in order to create a structured approach to describing the data. This involved the development of the specific research questions within this thesis whilst maintaining the wider richness and complexity of the data, building on the narratives written for each theme in Phase 3 that were refined through Phases 4 and 5. As such, Chapter 6 – Findings is a narrative exploration of the overall themes relevant to the given research questions. In effect, this final stage involved ‘zooming’ back out of the data to consider the broad themes and then back into the data in order to reconstitute them within the overall narrative of the Wellbeing Erewash project. In doing so I created the final themes and sub-themes of the research as represented in the different sections of the findings chapter – shown in Table 5-3 below (p.157).
### Table 5-3 - Final Themes and Sub-themes

<table>
<thead>
<tr>
<th>The Role of the Voluntary Sector in Wellbeing Erewash</th>
<th>Trust, Power, and Control in Wellbeing Erewash</th>
<th>Leadership</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Voluntary Sector in Project Planning</td>
<td>Trust: Trust as Part of Personal Relationships</td>
<td>Leadership Hierarchies</td>
</tr>
<tr>
<td>Erewash Voluntary Action</td>
<td>Personal Trust to Organisational Trust</td>
<td>EVA in the Hierarchy</td>
</tr>
<tr>
<td>EVA Hosting Meetings and Events</td>
<td>The Development of Trust Over Time</td>
<td>Quality for Health</td>
</tr>
<tr>
<td>The Story of Wellbeing Erewash</td>
<td>Trust as a Value</td>
<td>Clinical Leadership</td>
</tr>
<tr>
<td></td>
<td>Power: Balancing Power</td>
<td>Leadership as Individual</td>
</tr>
<tr>
<td></td>
<td>Power Through Personal Relationships</td>
<td>Relationships and Sharing Leadership</td>
</tr>
<tr>
<td></td>
<td>Power Through Funding</td>
<td>Leadership as Skill Development</td>
</tr>
<tr>
<td></td>
<td>Control: Top-Down Control</td>
<td>Leadership as ‘Getting Things Done’</td>
</tr>
<tr>
<td></td>
<td>Bottom-Up Control</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Middle-Down Control</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Middle-Up Control</td>
<td></td>
</tr>
</tbody>
</table>

(Source: created by author based on themes developed in NVivo and Excel)
5.4 The Role of Reflexivity

As explored extensively in Chapter 4 - Research Design, reflexivity is “an essential feature of qualitative inquiry that recognises the researcher as a human being who embodies emotions and multiple identities... [and it] is used to understand the personal, social, and political aspects of the research process and the kind of knowledge that is produced” (Trussell, 2014, p.344). Reflexivity is also important in order for researchers to recognise their own social characteristics (axiology) in relation to the issue they’re investigating and how that may have an impact on their work. Brannick and Coghlan (2007) describe these two aspects of reflexivity as ‘epistemic’ – focus on a researcher’s belief systems - and ‘methodological’ – monitoring the behavioural impact of the research on the research setting. Reflexivity is a “methodological self-consciousness” (Hibbert et al., 2014, p.238) that engages with notions of ‘otherness’. It cuts across different research strategies and approaches (Blaikie, 2000) but is of particular importance to ‘engaged’ research approaches (Coghlan and Brannick, 2010). Reflexivity has a long tradition in both organisational (Hibbert et al., 2014) and voluntary sector (Trussell, 2014) research and is a way of ensuring robust research processes in both research design generally and in analysis specifically.

Within Thematic Analysis, reflexivity is used to ensure appropriate consideration is given to the data – including alternative interpretations, and the researcher’s role in production of that data. It is also the ‘glue’ that allows a ‘reconstruction’ (Birks and Mills, 2011) of the data after initial coding has ‘fractured’ it; and helps to ensure quality through detailing a clear process and auditable structure of analysis. It is, as Trussell (2014) says, an important tool to “demonstrate the validity or trustworthiness of a research project” (p. 344). Within the analysis stage of my research, reflexivity meant a consideration of how codes were defined and developed, and how themes were chosen and constructed. The section on reflexivity in Chapter 4 – Research Design, gives an overview of how the process was applied to the research as a whole. This section provides some additional detail on how reflexivity was used during analysis.
Chapter 5 Analysis

Reflexivity during the analysis phase of this research was in many ways a continuation of the process from the rest of the research. The notes on general reflections continued. However, there were some specific aspects of reflection that were relevant to analysis. This relates to reflections recorded in the NVivo software to aid coding and theme development. Reflexivity worked in this context in the following ways:

1. As referenced previously, each node had a description attached to it, and any changes or contributions to the overall definition of the node or its meaning were noted in the relevant memo in NVivo. This allowed for changes to be tracked over time.

2. Each new idea for a potential theme was recorded in a memo and reflections in relation to that theme were recorded in the memo, with time stamps to allow the process of change to be observed. Each time a theme was added to or altered an entry was put into the relevant memo, along with a reflection on why that change was being made.

3. An NVivo memo was kept for ‘general notes on analysis’ in order to record my reflections whilst carrying out the work. This had the practical benefit of being a record of both what was carried out and how I felt. Changes to the overall analysis process did happen and this provided a space to think through why this was necessary.

4. It’s important to note that I also kept general reflections about the research process as a whole separately in Microsoft OneNote and this continued throughout the analysis phase. As a result, there was often overlap between the Nvivo reflections on analysis specifically and the general reflective notes. Maintaining both allowed for a consistency throughout the research as a whole. Reflexivity not only helps to detail a clear rationale for why decisions are made in analysis but can also contribute to analytical quality. Ensuring quality is an important part of any research project and so the next section will give an overview of how this was addressed.
5.5 Ensuring Quality in Analysis

Ensuring quality in Thematic Analysis is important but difficult. Although the flexibility offered by the method is generally seen as a good thing in that it makes the approach accessible and means it can be used on large amounts of data across different disciplines, it can hinder focus and generate such a depth and breadth of data that it is difficult to navigate. Similarly, there can be a lack of an explicit procedure unless the researcher is careful to include it specifically. Thematic analysis lacks a ‘brand’ and is not connected to any particular discipline, method or philosophical position which can lead to less support and less kudos (Braun and Clarke, 2006; Robson, 2011).

In addition to those general points there is also a specific need for an approach towards analysis that is demonstrably ‘scholarly rigorous’ (Gioia et al., 2012). Fortunately, both Braun and Clarke (2006) and Miles and Huberman (1994; also, Miles et al., 2014) provide guidance on ensuring quality and “judging the ‘goodness’” (Miles et al., 2014, p. 293) of qualitative research. Braun and Clarke’s approach sets out a 15-point checklist of criteria for good Thematic Analysis, which details best practice at each of their six phases of the analytical process. Table 5-4 on p.163 shows how each of the 15 points were applied to my research. Further, Miles et al. (2014) provide 18 points of quality to consider when carrying out Thematic Analysis. It’s important to note at this point that Miles et al. (2014) adopt a ‘pragmatic realist’ approach to their work, meaning that they place a greater emphasis on objectivity, generalisation to an external reality, and representativeness than is necessary for my research. This highlights the importance of fitting questions of quality with any overall research design. Of those 18 points, the following apply specifically to this research:

1) **Checking for representativeness** – rather than just accepting a finding from the data, any codes or themes developed from them were compared to the dataset as a whole in order to assess how relevant it was to the overall context. However, it’s important to note here that, as suggested above, the pure volume of coding was not the final arbiter of representativeness. As a researcher who had been heavily involved in the context in question I relied on my judgement in relation to representativeness. This included the number of
coded examples of an instance but also whether the analysis ‘made sense’ and whether I thought it represented what I had experienced in context. For example, one tweet that forms part of the data records the community representative being referred to as the ‘north star’ of the project. This jumped out to me as unusual and as a result I then searched the rest of the data for other instances of the community representative being treated in such a way. I was able to find several more examples which led me to consider how this impacted the role of the voluntary sector. This finding eventually formed part of the discussion around ‘transmission belt’ organisations.

2) **Checking for researcher effects – on the context and on the researcher** – this was particularly important for this research due to the highly engaged nature of it. Reflexivity played a large role in this as detailed above and in addition conversations with participants and with academic colleagues helped to draw out any researcher influence. It is important to note that at times researcher influence on the research context was entirely intended, often to draw out additional data. For example, during one meeting I introduced the concept of participant diversity into a discussion about the project, I had to be careful that I didn’t treat this as something that had organically happened as a normal part of the project but also that I didn’t dismiss what was said just because I had been the one that introduced the subject. It was important to identify this explicit researcher role in order to ensure quality.

3) **Triangulation** – this draws on the concept of triangulation as applied in Research Oriented Action Research (RO-AR). This approach seeks out a more robust understanding of a context by approaching it from as many angles as possible. Therefore, the triangulation in this research is between (1) the *observation* of events and social processes (participant observation and observant participation), (2) the *accounts* each participant offers for those events (interviews and conversations), and (3) the *changes* in these observations and accounts as *time passes* (from Eden and Huxham, 2006). The data from these three areas are not expected to agree; any disagreement between them is helpful in terms of iterative
development of findings. In this research, often the information gathered from interviews and informal conversations - which captured espoused opinions of participants - acted as cues to then investigate what happened in practice through observations and participation. The change over time was particularly noticeable in this research as the data contain far more in relation to sustainability as the project nears its end.

4) **Following up surprises** – inductive thematic analysis draws out findings from the data. This means that surprises often happen as there is a ‘suspension of belief’ during the analytical process. However, having lived with the data and having a high level of familiarisation with it, a certain level of expectation can develop in relation to the content of the data. Equally, many of the surprising aspects of the data had been reflected upon during data collection – as demonstrated in written reflections – however, during the formal coding process, any new areas or codes were compared back to previous codes and the dataset as a whole to check for additional examples.

5) **Replicating a finding** – this relates to following up surprises. Having ‘lived’ with the data for so long it is easy to make holistic conclusions about it from little data or sparse examples of an occurrence because of an interpretation made during data collection. As a result, a specific effort was made to find additional examples of codes and themes from other data as analysis progressed. The development of the thematic matrices helped to do this as chunks of data from different codes could be fed into a matrix to create a more robust account of each theme. For example, the development of the ‘info guides’ near the end of the project was shown in the data to have been a process that was relatively inclusive, which was surprising as I hadn’t consciously realised this at the time. I then when back to the data on how other aspects of the project were produced to see if this was similar or different to other examples and found that it was quite different.

6) **Getting feedback from participants** – feedback was a fundamental part of the research process. Through daily conversations with participants whilst ‘in the field’ I was able to check
my own understanding of events and to gain access to the interpretation of others. I was also able to trial potential findings to see if they ‘made sense’ to participants. After leaving the field I made three visits back to talk with participants about the research. The first was during the formal analysis, at Phase 4, when themes were being reviewed during which I solicited feedback from some participants about my developing findings; the second visit was after writing up had begun and was an opportunity to catch up with developments and to check if the themes I had arrived at were relevant to practice and again ‘made sense’; the third visit was to present my findings to the local Voluntary Sector Forum.

7) **Reliability** – Within this research this refers to having a consistent process of study; that research questions are clear, and the research design is detailed and followed.

8) **Internal validity** – linked to getting feedback from participants, this is related to whether the analysis is an authentic portrayal; that there is ‘thick description’ of the context in question, and that the final thesis ‘makes sense’.

9) **Application/utilization** – Further to whether the participants agree that it is an accurate portrayal of the context in question is the notion that they ‘get something’ out of participating. This research contributed to this in two ways. Firstly, taking part as an active member of the research context involved helping out with a variety of different tasks for the organisations involved – notably helping Erewash Voluntary Action achieve the ‘Quality for Health’ kitemark; facilitating discussions at community events; helping to develop the ‘Community Connectors’ post; contributing to written documentation produced by the project etc. This was a significant practical benefit to the organisations involved in the Wellbeing Erewash project. Secondly, this research aimed to produce practical guidelines for the participants and organisations involved. This proved difficult to achieve because of the fast-moving nature of local developments and changing relationships; individuals moving on to other jobs; cuts to funding etc. As a result, the relevance of findings to practice became less and less as time progressed. Because of this, some general guidance was produced in
In summary, ensuring quality is vital in Thematic Analysis. This requires an explicit account of the process of analysis so that links to both the research context and any wider applicability can be examined. Crucially, for engaged research that seeks to both capture and influence practice, involvement of participants in formative and summative consideration of findings as they develop is an important aspect. This research followed a structured approach to analysis; used reflexivity extensively to track the development of codes, themes, and final findings; made the researcher role explicit; and developed findings and a written report of those findings that ‘makes sense’. The next section briefly identifies those findings before detailing them fully in Chapter 6 - Findings.
### Table 5-4 - 15 Point Checklist for Good Thematic Analysis

<table>
<thead>
<tr>
<th>Phase</th>
<th>No.</th>
<th>Criteria</th>
<th>Applied to this research</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transcrip</td>
<td>1</td>
<td>Data transcribed to enough detail and transcripts checked against record</td>
<td>Recordings were transcribed verbatim by the researcher and compared with written notes taken at the time of interview.</td>
</tr>
<tr>
<td>tion</td>
<td></td>
<td>ings for accuracy</td>
<td></td>
</tr>
<tr>
<td>Coding</td>
<td>2</td>
<td>Each data item is given equal attention in the coding process</td>
<td>Each item of data was coded in NVivo, each code was given a description and had a ‘memo’ attached so that notes and changes could be recorded and developed.</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>The coding process is thorough, inclusive, and comprehensive, rather</td>
<td>This research followed the ‘Six Phases’ in a reflexive and iterative way as demonstrated by the range of codes developed and the reflexive accounts generated.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>than ‘anecdotal’</td>
<td></td>
</tr>
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<td></td>
<td>4</td>
<td>Relevant extracts from each theme have been collated</td>
<td>These are coded in NVivo, in the matrices developed in Excel, and in the narratives generated from those matrices.</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>Themes have been checked against each other and against the original</td>
<td>Developing themes were checked with the overall data to see if they ‘made sense’; the final themes selected were compared with each other to check for duplication and to establish a coherent narrative for the report findings.</td>
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<td>data set</td>
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<td></td>
<td>6</td>
<td>Themes are internally coherent, consistent, and distinctive</td>
<td>In addition to the themes ‘fitting’ together, they were also assessed in line with whether they contributed to answering the given research questions.</td>
</tr>
<tr>
<td>Analysis</td>
<td>7</td>
<td>Data have been analysed rather than just described</td>
<td>Although the nature of this research is highly descriptive, analytical categories were developed and presented in the findings, including synthesising different codes to create themes and drawing out explanations for findings. This links to the discussion chapter.</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>Analysis and data match each other – extracts illustrate claims</td>
<td>Themes come from the data inductively and direct extracts are used to illustrate this link.</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>Analysis tells a convincing story about the data and topic</td>
<td>Findings were chosen to provide a coherent narrative and reviewed.</td>
</tr>
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<td>10</td>
<td>Balance between analytic narrative and illustrative extracts</td>
<td>Specific examples from the data are given where appropriate.</td>
</tr>
<tr>
<td>Overall</td>
<td>11</td>
<td>Enough time has been given to each stage of the analysis</td>
<td>An analysis plan was followed that included a timeline.</td>
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<tr>
<td>Written</td>
<td>12</td>
<td>The approach to analysis is clear</td>
<td>The analysis section sets out the approach.</td>
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<td>Report</td>
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<td>13</td>
<td>There is a fit between what you claim you have done and what you actually did</td>
<td>The analysis section is a description of what actually happened during the research, reflections help to back up this claim.</td>
</tr>
<tr>
<td></td>
<td>14</td>
<td>The language and concepts of the written report of analysis are</td>
<td>Claims are not made to broad generalisation or objectivity as this research is highly context driven. However, some application to other contexts is possible.</td>
</tr>
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<td>consistent with the epistemological position of the analysis</td>
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<td></td>
<td>15</td>
<td>The researcher is positioned as active in the research process</td>
<td>My role as researcher has been clearly identified, including interventions in the research context and my own motivations (axiology) for carrying out the research.</td>
</tr>
</tbody>
</table>

(Source: Adapted from Braun and Clarke, 2006, p.36)
Chapter 5 Analysis

5.6 Link to Findings Chapter

Writing the report of analysis is the final phase of Braun and Clarke’s (2006) Six Phases of Analysis. The full detail of the findings that were generated from the analytical process identified above will follow in Chapter 6 - Findings. As an introduction, the themes are as follows:

1) **The Role of the Voluntary Sector in Wellbeing Erewash (WE)** – this theme captures the profile the voluntary sector had in policy documents, ‘official’ accounts of the project, and in what actually happened in practice. The data suggest that there is a difference between the policy that suggests the voluntary sector should play a large role in projects such as WE and practice in which the sector is missing from several aspects of the project.
   Erewash Voluntary Action benefitted from a much higher profile than any other voluntary sector organisation, in part because of its status as the official ‘lead’ organisation for the sector’s involvement with the project.

2) **Trust, Power, and Control** – ‘control’ was a term used extensively throughout WE. Four elements of control were identified within the data: top-down; bottom-up; middle-down; and middle-up. The voluntary sector was mainly confined to the ‘middle’ aspects; the ‘top’ occupied by mainly NHS or other Public Sector organisations; and the ‘bottom’ was the domain of individual citizens/patients/service users and their collective representation in ‘communities’. These of course were relative concepts in that the position of any organisation or individual largely depended on who else was involved.
   Trust had a large presence in the data and had several different aspects, primarily relating to personal relationships. Power was less explicit in the data, but various dynamics existed throughout in relation to how the project worked in practice, particularly as regards funding and convening of the project. Trust and Power both relate closely to control.

3) **Leadership** – In much of the policy and interview data there was an emphasis on sharing leadership through collaboration between organisations. However, in practice the hierarchy of the NHS and in particular the dominant clinical professionalism meant that sharing was difficult. The voluntary sector – through EVA – did have a place in this hierarchy but also worked outside of it in order to ‘get things done’ and move their work
As such, leadership in this context was complex and multifaceted combining aspects of shared, individual, and hierarchical aspects.

5.7 Summary of Analysis Chapter

This chapter has detailed the approach to analysis carried out in this research and has justified why that approach was taken. The analysis was thematic and inductive, identifying findings from the data through coding and then aggregating those codes into themes. The process of analysis broadly followed Braun and Clarke’s (2006) ‘Six Phases of Thematic Analysis’ but with some modifications to fit the particular needs of this research. This is in line with Thematic Analysis as an approach in that it allows for flexibility and does not necessitate the following of a strict process in order for analysis to be valid. The chapter also detailed how reflexivity contributed to the analytical process. This included the consideration of alternative interpretation and researcher influence in terms of the identification and development of codes and themes from the data; ensuring a quality analysis was carried out through reflection on the process of analysis itself; and linking findings back to context by reflecting on whether they ‘made sense’. The themes of the findings chapter were then briefly mentioned as both the final point of the formal analytical process (following the journey to the end), and as an introduction to Chapter 6 - Findings, which follows next.
Chapter 6. Findings

6.1 Introduction to Chapter 6

This chapter presents a detailed account of the results of the inductive, thematic analysis described in Chapter 5 - Analysis. What follows below are the relevant findings as related to the research questions as detailed in Chapter 4 - Research Design. These findings provide the foundations for Chapter 7 - Discussion which explores the findings in relation to the previous literature detailed in Chapter 3 – Literature Review.

The first section will give a broad overview of the voluntary sector in the Wellbeing Erewash (WE) project in order to provide context for the following sections and to introduce aspects of the findings that relate back to the previous literature on cross-sector working. This includes how the gap between policy and practice played out in this context, how the voluntary sector (VS) was missing from key aspects of the project, and the role of Erewash Voluntary Action (EVA) as both a ‘route into’ and a ‘voice for’ communities. The second section considers the aspects of Trust, Power, and Control inherent in the project. The literature review identified these as key elements in collaborative relationships between the voluntary and public sectors, and they were emphasised in the data in various ways. Personal relationships played an important role in both trust and power and they in turn influenced the stated aim of the project to ‘share’ control and devolve it to communities in a ‘bottom-up’ sense. EVA found themselves in the middle of this control function. The final section considers aspects of leadership within the project including the role of hierarchies in the NHS, particularly in relation to clinicians; the role of EVA in that hierarchy; the leadership project delivered by the East Midlands Leadership Academy; and the ability of EVA to ‘get things done’ within the project. The findings show that the voluntary sector can play a leadership role in collaborative settings, supporting some of the previous literature on this topic.
6.2 The Role of the Voluntary Sector in Wellbeing Erewash

6.2.1 Introduction to The Role of the Voluntary Sector in Wellbeing Erewash

This section gives a general overview of the role of the voluntary sector in Wellbeing Erewash (WE). The concept of ‘role’ has been widely used in the academic literature that focuses on the voluntary sector, particularly in relation to its relationship with the public sector (see Rochester, 2013; Milbourne, 2013; Macmillan 2016; Hemmings, 2017) and although the notion is often undefined, its use tends to fit with the dictionary definition as: “the position or purpose that someone or something has in a situation, organization, society, or relationship” (Cambridge English Dictionary, 2019). Therefore, ‘role’ in this context refers to the part played by the voluntary sector (VS) within the WE project. It includes how the voluntary sector was conceived in planning and how this planning was implemented in practice both in terms of how the VS was treated by others and in how the sector itself worked. As the majority of engagement with the sector within the project was through Erewash Voluntary Action (EVA), their position will be considered in detail. I will also note the role of the voluntary sector in the story that was told about Wellbeing Erewash in both project evaluations and policy overviews.

6.2.2 The Voluntary Sector in Project Planning

The Five-Year Forward View and New Care Models (NCM) documents set the overall context for the introduction of the NHS Vanguard projects in England. The NCM document in particular emphasised the voluntary sector and volunteers as ‘key partners and enablers’. With this national policy picture as a background – detailed in Chapter 2 -Context - this section gives an overview of the specific planning that went into the Wellbeing Erewash (WE) project.

Initial planning took place during 2014 and early 2015 and so was not covered by the timescales of data collection (April 2017 to March 2018). However, some of the documents and discussions during this period were accessible because of the record keeping of one research participant. This included meeting agendas and minutes, emails, notes and the product of various workshops and discussions. These were all in hard copy format. There were also some documents publicly available on the WE website. Overall, these data suggest a high profile for the VS although with
some notable variations around definitions and expectations. In particular, a ‘vanguard stakeholder map’ was produced during the early conversations regarding WE that rated organisations and other potential partners in terms of both their ‘interest’ in the vanguard and their potential ‘influence’ on it. This appeared (but was not specifically outlined) to be on a five-star scale, with five being the highest rating and one being the lowest. The voluntary sector as a whole was listed as having a three-star rating for interest and a three-star rating for influence. For context, this was a higher rating than was given to the education sector, other non-primary care NHS organisations, the local council, and the media. It was the same rating as given to GP practices. ‘Local community groups’ were listed separately to the voluntary sector but with the same three-star rating. The ‘community partnerships stakeholder map’ produced in the same period listed EVA as a specific organisation (as ‘Erewash CVS’) rated three stars for both interest and influence. This was the same rating in this document as ‘individual members of the public’ and a separate entry for ‘voluntary organisations’ – notably not ‘the voluntary sector’ or ‘community organisations’ – and higher than the rating given to schools, the 50+ forum, the local Dementia Alliance, and Age UK who were listed as a separate organisation despite being in the voluntary sector. Finally, in relation to these particular documents, a stakeholder list for the specific ‘Community Resilience’ aspect of WE listed ‘Erewash CVS’ as having high interest, with engagement being through the CEO’s presence ‘on the workstream’, and that local engagement with ‘voluntary organisations’ would be ‘through CVS’ and the Voluntary Sector Single Point of Access (VSPA) service, which was hosted elsewhere.

In summary, we can take away from these documents that public sector engagement with the voluntary sector was generally through EVA and specifically through the EVA CEO being included in the ‘Community Resilience’ workstream. Notable in this is that the voluntary sector seems, from the start, to have been restricted to participation in the specific ‘Community Resilience’ (later ‘Community and Personal Resilience’) aspects of WE, rather than the clinical side (‘Primary and Integrated Care’).

There were also three separate ‘logic models’ created for the project. The model for ‘Integrated Service Delivery’ does not include any reference to the voluntary sector other than noting that
engagement will be through the VSPA service. The ‘Community Resilience’ Logic Model doesn’t include any reference to voluntary sector involvement although it does note the sector has a representative on the county Health and Wellbeing Board and that that board would be involved in discussion around how WE worked. Despite not referring to the voluntary sector, this logic model does refer to ‘natural communities’, ‘community leaders’, ‘project/community development workers’, ‘local priorities’, and ‘local people’, any of which could potentially be used to describe the constituent parts of the voluntary sector itself. Finally, the ‘Personal Resilience’ Logic Model states that WE will “Work in collaboration with the Voluntary Sector to enhance their input into the self-care and shared decision-making support for patients” i.e. that the VS will contribute to self-care and decision-making specifically, rather than have a general input into the Personal Resilience workstream as a whole.

A final note in relation to planning is that the voluntary sector as a whole, and EVA specifically, did not have any official liability in relation to ‘risk’ in Wellbeing Erewash, in contrast to NHS organisations. It was not clear why this was, but one participant speculated it may have been because of the relatively small size and financial vulnerability of voluntary sector organisations, and EVA in particular, i.e. it would not have been ‘fair’ to expect EVA to assume any risk in light of the fact that the liability was primarily financial and EVA’s financial size was very small in comparison to the NHS organisations involved.

The confusing use of terminology in relation to the voluntary sector used in planning documents - such as separating the sector from ‘community groups’, and detailing individual organisations separately to ‘voluntary organisations’ as a whole - makes it difficult to build up a complete picture of what is meant by the ‘voluntary sector’ in the context of WE. However, it’s clear that the sector was acknowledged in planning as being of importance, even if the logic of how they would be involved was not clearly articulated. In addition, much of the interview data captures how participants echoed these policy documents in how they spoke about the sector, from both the NHS and VS sides. This included the idea that the project had developed a greater ‘profile’ for the sector as a whole (Interviewee 10 – voluntary sector employee); the sense of a shared ethos, culture, and ‘ways of working’ around recovery and resilience (Interviewee 18 – voluntary sector employee).
Chapter 6 Findings

employee); and the compatibility of ‘asset-based’ approaches (Interviewee 21 – voluntary sector employee). However, there was sometimes confusion about what exactly the voluntary sector was – essentially how it could be defined. Public sector interviewees described the voluntary sector as “key” (Interviewee 53 – NHS employee) and “really central” (Interviewee 83 – NHS employee) to the success of WE. This was based on the idea that the voluntary sector was “better placed to support the needs of the community.” (Interviewee 50 – NHS Employee). Some participants did note negatives in relation to working with the voluntary sector, such as frustrations with risk aversion (Interviewee 83 – NHS employee) and a lack of receptiveness to new ways of working (Interviewee 17 – NHS employee) in the sector. The question that these observations gives rise to is how the project worked in practice. The next section will explore this.

6.2.3 The Voluntary Sector in Practice

Despite the reflection of policy in the opinions of participants, what happened in practice paints a different picture and amounts to the sector being missing from key aspects of project delivery. As detailed above, the planning documents for Wellbeing Erewash (WE) list both the general voluntary sector (VS) and Erewash Voluntary Action (EVA) specifically as important in relation to the implementation of the project. However, the ‘Value Proposition’ document for WE – which was produced at the start of the project but ‘refreshed’ in February 2016, near the end of year one – states that, rather than being an integral part of WE, the voluntary sector would be involved only after GPs and NHS community services had established the ways of working of the project (Wellbeing Erewash, 2016a). The VS was also not identified as a ‘partner’ in the official definition of WE used throughout the project. All of those listed were NHS organisations:

Text Box 1 - Quote from Wellbeing Erewash Newsletter #1

Wellbeing Erewash, the MCP ‘vanguard’ in Derbyshire, is a partnership between Erewash CCG, Derbyshire Community Health Services, Derbyshire Health United, Derbyshire Healthcare Foundation Trust and Erewash Health. We also work closely with the voluntary and social care sector.

Wellbeing Erewash, Newsletter #1, p.1
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The voluntary sector’s contribution to WE was exclusively confined to what became the ‘Community and Personal Resilience’ (CPR) workstream of the project. At no point in the data did voluntary sector representatives engage directly with any of the aspects of the Primary and Integrated Care workstream. The sector’s involvement in meetings related to the CPR work was also mixed. Initially, workstream meetings would be attended by multiple voluntary sector organisations who had an opportunity to contribute to the discussion. The meeting of the 13th of April 2017 was a typical example and attended by four VS representatives from three different organisations. These meetings were part of an approach designed to bring the two opposing workstreams closer together and the format of them was explicitly designed to allow for sharing of information across the two. The first hour was devoted to Community and Personal Resilience, the second to joint issues across the two workstreams and the final hour to the Primary and Integrated Care aspects. However, the separation between them was starkly demonstrated in that when the final hour came, all of the voluntary sector representatives left the meeting. It is also important to note that the VS was overwhelming outnumbered by public sector (mainly NHS) employees throughout these meetings. In the 13th of April meeting this was twelve to four in the first hour; twenty to four in the second. Although there were times where the numbers of voluntary sector organisations matched those of the public sector, this was entirely due to a decrease in public sector attendees. Hour one of the meeting of the 14th December 2017 for example contained five public and five voluntary sector representatives and the apologies from public sector workers were noted.

Decreasing public sector involvement was an increasing problem as the project neared its end. Participants moved into different roles, back to their original posts, or left their organisations completely as is typical in collaborative contexts (Huxham and Vangen, 2000b). In the final workstream meeting before the official end of WE, one NHS participant noted that people were “abandoning” the project, and another suggested it was “like a death” had happened. This contrasts with the espoused commitment made by participants during sustainability discussions that the ‘ways of working’ developed as part of WE would remain because people were committed to them.
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Further, in relation to the voluntary sector profile as a whole, at the planning meetings for the vanguard, very early during data collection (in the overall context of WE therefore, very early in Year 3 of 3), two further meetings were established by the local CCG that sat above the WE meetings and were designed to have a broader remit to instigate a move to ‘Alliance’ ways of working. The voluntary sector was identified in the ‘Alliance Engagement Strategy’ as one of three ‘sets’ of people that the NHS – through these new meetings – should engage with; they were not seen as valuable to engage in their own right but as “those who represent communities”, with communities “being defined by the common factor that brought people together”.

Despite this acknowledgement that the VS were at least in some part important to engage, the voluntary sector profile within these meetings was initially zero – one participant noted during a conversation on the 4th of April 2017 that there had not been any contact at all with the sector regarding representation. Later, the sector was granted one place on the ‘Management’ meeting and this was given to the CEO of Erewash Voluntary Action. The sector never had a presence on the higher level ‘Leadership’ meeting. This is important as it had been made clear that the group would have the final say in relation to the work carried out in Erewash moving forward.

**Text Box 2 - Extracts from Field Notes 18th February 2018**

[NHS employee] noted that “this room” has the authority to approve spending as “this is the vanguard governance structure” ...

...[NHS Employee] asked if everyone had a clear view of what this meeting was for and that moving forward they need to move beyond going to the CCG for approving everything and approve things here BUT that it’s beyond the vanguard and “this is it” for Erewash – implying it’s the sole decision-making group for Erewash.

Field notes from Alliance Leadership Meeting 13th February 2018

The voluntary sector, in addition to not having a physical presence in practice at the Leadership meeting, also had very little presence in what was discussed. For example, a discussion around social prescribing and the Community Connectors role at the meeting of 14th November 2018 included no mention of the voluntary sector despite the fact that the Community Connectors initiative is led and run by Erewash Voluntary Action. The discussion focussed on the work of NHS staff in setting up links with GPs. The voluntary sector was also missing from some of the more
celebratory events of WE, particularly as they related to the national profile of the project. This was highlighted in the data during ‘visits’ from senior NHS England employees and other well-regarded individuals who were escorted around various elements of WE to demonstrate to them the ongoing success of the project. When I mentioned one visit to EVA employees, they did not have any knowledge it had happened and had not received any invitation to be involved. In addition, the positive results of the commissioned evaluation of EVA’s contribution to the project were not discussed or considered in these meetings, despite one NHS employee noting that the figures were ‘mind blowing’ (in a positive sense).

In summary, the voluntary sector was excluded from some important aspects of WE as the project progressed, particularly as the focus shifted to ‘Alliance’ ways of working. This coincided with moves to have the sector represented by a single organisation – EVA – rather than inviting multiple attendees from the sector. The next section will consider the role of EVA specifically.

6.2.4 Erewash Voluntary Action

Much like the voluntary sector generally, interviewees spoke about EVA in largely positive terms. Several interviewees from both the voluntary and statutory sectors specifically noted the importance of EVA in relation to how they worked in the local context. Interviewees often identified EVA – and the Chief Executive in particular – as having a leading or controlling role over the Community and Personal Resilience aspects of WE, alongside the named NHS lead. NHS workers specifically saw EVA as the single important VS organisation and assumed EVA would both represent the rest of the sector and be a route into it. Some interviewees did note that this situation was not ideal, and that wider involvement of other VS organisations would be preferable.

Text Box 3 - Quote from Interviewee 53

The CVS is not the voluntary sector, and that’s who we have chosen to engage with, partly to do with practicalities I guess and having one key point of contact, rather than trying to go out and collate lots of different views.

Interviewee 53, NHS Employee
Others suggested funding restrictions and the rise of competitive funding through contracts have led to a reduction in capacity in the sector to carry out community representation and engagement. The general consensus amongst interviewees was that the voluntary sector as a whole, and by implication - due to the sector being equated with them – EVA, were used as a “bit of both” (Interviewee 7 – NHS employee); a voice for the sector and a route into it. This was extended more widely to assume the voluntary sector as whole could both represent communities and be a route into them.

In practice, much like in interviews, NHS staff did at times acknowledge EVA were not able to represent the entire sector. During a discussion at an Alliance Management meeting an NHS employee noted to the EVA CEO that “you are not the voluntary sector”. However, the very presence of the EVA CEO as the singular VS attendee was for them to act as a representative of the whole sector. As much as EVA was seemingly considered to be commensurate with the VS as a whole, the role of the EVA Chief Executive in turn often seemed to be commensurate with EVA as an organisation, and therefore by extension, also with the VS as a whole. This was noticeable within the East Midlands Leadership Academy workshops – explored in Section 6.8 – Leadership. The EVA CEO input into these sessions was welcomed as ‘the voluntary sector voice’. The EVA CEO was also named as the ‘lead’ for the ‘Strengthening the Voluntary Sector’ aspect of the WE project. There was no explicit acknowledgement here that EVA itself was part of the sector that needed to be strengthened.

6.2.4.1 EVA Hosting Meetings and Events

Erewash Voluntary Action (EVA) benefitted from having a large office and meeting space in Erewash and this allowed them to host a variety of different meetings, training, and events, including the ‘Quality for Health’; and ‘Health as a Social Movement’ aspects of the work. EVA also hosted two regular forum meetings as part of their involvement in WE, the ‘Voluntary Sector’ and ‘Development Workers’ forums. These were administered by EVA, chaired by EVA staff, and any information that came out of the meetings was collated and fed back to both attendees and the wider project by EVA. However, the impetus for the sessions was created by the WE project as
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part of the ‘Strengthening the Voluntary Sector’ aspect of the ‘Community and Personal Resilience’ workstream. They would not have existed without that driver.

The official description of the ‘Voluntary Sector Forum’ (details in Appendix) suggested a broad definition of the sector and a focus on practical issues in order to ‘build capacity’. However, the stated aim of the forum noted that it would act as “a strategic platform to influence and raise concerns and issues facing the voluntary sector”, which suggests a focus more towards some ‘other’ area at a strategic level. Stated objectives included references to communicating and working with public and private sector agencies in partnership and developing and promoting the collective views and interests of the voluntary sector. Despite this emphasis on influencing areas other than the voluntary sector, the opportunity to do so had not materialised in a formal sense during the life of WE. This lack of opportunity to feed ‘upwards’ into other meetings and decision-making groups meant that it existed more as a way for the voluntary sector to share information and ways of working, and for the NHS to deliver information via EVA. EVA also had a wider role in feeding information upwards from their position in the ‘middle’ as Section 6.6 – Control will explore. Membership of the forum was limited to the ‘voluntary sector’ which was defined in the Terms of Reference as “any constituted voluntary organisation including groups registered with the Charity Commission and/or Companies House, independent of (local or central) government”. Notably that definition does not exclude groups that are not registered, meaning potential membership is quite large.

The Development Workers Forum (see description in Appendix) aimed to “bring together individuals who support clients in the Erewash area to share skills, information, experiences, good practice and resources.”. Its objectives broadly matched those of the Voluntary Sector Forum however it was open to all people in voluntary, private, and public sector organisations delivering ‘front line’ services. EVA also ran and/or hosted several other meetings in their building including a ‘Volunteers Forum’; a ‘Children and Young People’s Network’; the ‘Mental Health Partnership’; and ‘Future in Mind’ (childhood wellbeing). EVA also hired out their rooms to other organisations. This amount of activity in the physical space of EVA meant that a lot of volunteers, workers,
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service users, and general members of the public were aware of EVA, although how far this awareness reached cannot be stated without further research.

In summary, EVA’s position in the project, as with the VS as a whole, was mixed. They were at times acting as the voice of the sector and at others as a route into it. At others still, they were acting as both at the same time or as an overseer and/or mediator. This complex picture was found both in practice and in how participants spoke about the project when interviewed.

The final aspect of the role of the voluntary sector in WE is how the story of the project was told as it came to an end, both by national and local stakeholders.

6.2.5 The Story of Wellbeing Erewash

As noted above, the voluntary sector was not officially included as a ‘partner’ in the documents produced as part of WE. The sector was however seen as important in both policy and in the comments of practitioners but excluded from certain areas in practice. Although EVA benefitted from a more prominent position than any other sector organisation, they too were excluded from key aspects of the project. For example, despite the fact that EVA were identified as a key organisation in planning documents for WE very little reference was made to their work outside of the specific context in which they contributed. At times even when elements of the project that EVA had been heavily involved in – such as the Community Connectors initiative – were referenced in reports, meeting minutes etc. EVA were often not mentioned by name. The EVA Chief Executive was referred to personally at times, primarily in their capacity as lead for the ‘Strengthening the Voluntary Sector’ work.

EVA, and the voluntary sector as a whole, were also missing from the official story - the account of what happened in the project - of Wellbeing Erewash. Locally, several documents were produced that told the (invented) journey through life of a local resident, highlighting what had changed for them and their family as a result of WE. The intent of this story was to influence key decision makers and create a positive image of the project to a general audience. The story had been produced by an external PR agency and was the result of a process that involved input from NHS
and voluntary sector workers. Despite this input, the final product did not include any direct reference to the role of EVA or the VS as a whole. In contrast to this, several ‘info guides’ were also produced that were developed with much broader input, including a session at one of the forum meetings held at EVA at which participants were able to sketch out the content of the guides. These guides were intended to be used by practitioners in other areas to introduce similar ways of working to those enacted as part of WE. These documents included several references to working with communities and to thinking beyond the statutory health and social care sectors, reflecting much of what had been written in the WE planning documents. They also contain specific references to the work of EVA, and other voluntary sector organisations. Nationally, the Local Government Association, NHS Clinical Commissioners, NHS Providers, and NHS Confederation produced a series of ‘Vanguard Briefing’ documents that suggested the involvement of the voluntary sector “can be particularly valuable for understanding the needs of local populations and delivering person-centred services that transcend traditional service divides.”.

Text Box 4 - Extract from ‘Learning From the Vanguards’ document, p.3

- Developing relationships and partnership with the voluntary sector can be particularly valuable for understanding the needs of local populations and delivering person-centred services that transcend traditional service divides. The Isle of Wight vanguard has worked with Age UK to develop the role of care navigators who support people to get the right support to manage a wide range of health and care needs

The profile of the VS in policy documents seems then to have been maintained throughout the course of the vanguard projects and, if anything, been reinforced or vindicated through its inclusion in these suggestions of ‘what worked’. However, at a local level, the voluntary sector was missing from the story created – primarily by the NHS - as part of the practice of the project itself. When the story was told in a collective way – as in the ‘info guides’ – the role of the voluntary sector was included.
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6.2.6 Summary of the Voluntary Sector in Wellbeing Erewash

This theme has highlighted the mixed picture in relation to the role of the voluntary sector in the Wellbeing Erewash project. In particular, it has drawn attention to the various aspects from which the sector was missing or had a relatively minor role in practice, despite what was suggested in policy/planning documents at the start, or the story of the project presented at the end. Despite the mixed picture for the VS as a whole, Erewash Voluntary Action (EVA) had a much higher profile than other organisations. There are many potential reasons for this, not least their previous relationships with the local CCG and that they were identified in planning documents to be of high importance. However, their involvement in practice was limited both in terms of access and contribution. It was also unclear as to whether their involvement was acting as a legitimate voice for the sector, a route into the community, or even as a single and/or self-interested organisation. These different roles were often in tension with each other, and with other participants in the project. In particular, relations between organisations and individuals relied on the trust that had built up between them over time. Trust itself is a key aspect of collaborative ways of working and is closely related to notions of power and control, as detailed in Chapter 3 - Literature Review. The next section will explore elements of Trust, Power, and Control in the project.

6.3 Trust, Power, and Control in Wellbeing Erewash

6.3.1 Introduction to Trust, Power, and Control

The previous section explored the role of the voluntary sector within Wellbeing Erewash. A mixed picture was detailed, particularly in relation to the gap between policy aims and implementation in practice. The voluntary sector was found to be limited in terms of how and where it could operate within the structures of the project. The following sections explore the notions of trust, power, and control within the project, starting with the concept of trust.
6.4 Trust

This section will detail the findings of the research in relation to Trust, Power, and Control that emerged from the data as important aspects of the project.

Firstly, several different aspects of trust were identified in the data:

- Trust as part of personal relationships
- The development of organisational trust from personal trust
- The development of trust over time
- Trust as a policy goal

The following sections will detail each of these in turn.

6.4.1 Trust as Part of Personal Relationships

The majority of the data that refer to the concept of trust relates to the role it plays in relationships. This was most often about personal relationships but did also touch at times on relationships between organisations and sectors. This idea of trust was expressed both in policy documents and espoused by participants. The 2016 refresh of the ‘Value Proposition’ for WE stated that success would be built on “good relationships and trust” (p.17) and this was echoed in the ‘Alliance Strategy’ that followed it which stated the importance of trust, equality and reciprocity in public/patient relationships. A typical example of how participants referred to trust can be found in notes from the Alliance Leadership Meeting of February 2018 in which a senior employee of an NHS organisation noted that ‘Trust, Relationships, Honesty and Funding’ were the key elements of success in Erewash.

From the voluntary sector side, the Nesta Health as a Social Movement report (del Castillo et al., 2016) also notes the need for “relationships based on trust” (p.27). The EVA CEO identified ‘Trust’ as the most important element of WE when asked at an event in March 2018. Staff spoke about the ‘trust’ they had from managers and trustee boards to get on with their jobs.
Interviewees often mentioned the notion of ‘trust’ and when pressed on its meaning related it to different elements, such as the ability to have ‘open and honest’ conversations and ‘disagreements’ between partners, without disrupting relationships.

Others noted that trust was about having a shared understanding of what each other does and the challenges faced (interviewee 97 – NHS employee), and about respecting each other and embracing the notion that in WE stakeholders were ‘all in it together’ (interviewee 50 – NHS employee). There were concerns raised about ‘losing’ trust if efforts to maintain personal relationships were not continued (interviewee 97 – NHS employee) and also about the ability to trust in others if delegating to them (interviewee 10 – voluntary sector employee).

We can see this notion of trust and relationships play out in practice in interactions between different individuals, such as CCG employees feeling that EVA was a safe space for them to ‘have a moan’ about their working lives, detailed in Section 6.6.1.3. This use of EVA as a safe space seemed to also be true for members of the public who would visit EVA for informal support, often very casually, infrequently, and not related to any particular service or activity. Another aspect of practice that highlights trusting relationships was the link between the EVA CEO and the NHS project lead for the Community and Personal Resilience workstream. They appeared to have a positive personal relationship and the link between them enabled much of the project’s work to progress. However, this relationship suffered due to the effects of time on the project. Section 6.8 explores this dynamic further through the lens of leadership.

6.4.2 From Personal Trust to Organisational Trust

For the most part, trust across organisations was seen as an extension of trust developed through personal relationships. Interviewees described the need to ‘start somewhere’ (interviewee 10 – voluntary sector employee) to develop an ‘element of trust’ (interviewee 61 – Local Authority employee) across their organisations. The logic appeared to be that trust would develop between organisations automatically over time. This was contradicted somewhat in that the loss of key individuals was universally referenced as damaging to the ways of working of the project, particularly when the voluntary sector lost advocates in the NHS. In addition, much of the project
involved collaboration between organisations who had at least some recent history of working together, however, most of the individuals involved were different. This emphasises the important of personal aspects of trust from the voluntary sector perspective.

The notion of ‘assumed trust’ was also referenced in the sense that other individuals within organisations could use the idea of trust that had been built up by others in the organisation through their own personal relationships over time. This assumed trust provided a short-cut to other elements of the project or for new staff entering the project at a later date. However, this seemed to be ‘assumed’ from those in more powerful positions and exclusively those in the NHS.

There was assumed trust in relation to certain organisations – notably the voluntary sector - and also in the way that it was assumed the sector had trust with communities, reflecting the suggestion that the sector are ‘key partners and enablers’ in community service delivery. This at times seemed to be used in an instrumental way to express that there was trust – in the knowledge that trust is a vital part of working together – rather than having any real evidence or experience of trust in action. In contrast, voluntary sector employees that were new to the project or area not only found it difficult to make initial inroads within the project itself but also with the communities they were assumed to be working with. This was articulated by one participant who expressed frustration that no one seemed to trust them in the community they were working with (interviewee 97 – voluntary sector employee).

Assumed trust appeared to act as a bridge between those in the project who had built up trust through personal relationships over time and those who were new, but this was mainly for those in the NHS and in more senior positions. In practice, this meant that at times organisations were assumed to be able to carry out work for the project, for example, the Community Connectors project was given to EVA to deliver. EVA were also present in meetings and at events in order to give a trusted opinion about the voluntary sector and about the communities they work with. In this sense EVA was trusted to give a voice and empower the rest of the voluntary sector.

However, as I observed in my field notes in April 2017, there was no opportunity to test the engagement processes that had been set up as part of the project (the Forums run by EVA) in
practice because there had been no issues given to them to engage on. It appeared they were there for show rather than to have any practical use.

Text Box 5 - Extract from Field Notes - 19th April 2017

[VS Employee] said EVA haven’t been able to ‘test’ engagement yet because the CCG haven’t come to them with an opportunity, i.e. they haven’t said ‘what does the VS think about X?’

Field notes 19th April 2017

At times, a lack of trust between individuals affected whether organisations were willing to work together. Two voluntary sector organisations that would have benefitted from closer work did not do so because of a lack of trust and an excess of distrust based on previous interactions. Employees from one organisation actively discussed that they were unwilling to work closely with the other for fear of being tainted by their failure. This distrust also spread to others in the project, in particular the suspicion in the former organisation that NHS workers involved in the project were actively attempting to manipulate them to support the failures of the other organisation in order to ‘save face’.

Text Box 6 - Extracts from Field Notes - 2nd and 23rd May 2017

[VS Employee] spoke about not wanting to bail out [organisation] and that there is no good will there to facilitate that happening. It’s a [organisation] project and they have been funded for it, but it’s really disorganised with little staff commitment.

Field notes 2nd May 2017

[VS Employee] noted her suspicion about [NHS Employee] wanting to see her when [VS Manager] isn’t there. Said it had only been arranged yesterday. [VS Employee] thinks this was to try and influence [them] towards working with [organisation]

Field notes 23rd May 2017

6.4.3 The Development of Trust Over Time

The ‘speed of trust’ was referenced by participants as a key factor in mediating any progress made in the project. This was expressed in a temporal sense: individual relationships are key and come first, before then moving to the organisational level. Interviewee 10 – from the voluntary sector – also spoke about the ‘early days’ of trust being one-to-one before becoming organisational. In addition, trust was seen as existing prior to the project being established, having
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been developed through previous organisational working over many years. This was mixed in relation to whether the voluntary sector was or was not included.

Despite the positive relationship between trust and time, time was also detrimental to trust in several ways. Firstly, as individuals left the project trust between organisations and across relationships suffered. This highlighted where personal relationships had not become embedded in organisational trust. Secondly, as sustainability became more of an issue later in the life of the project, organisations became concerned with their funding and individuals became concerned with their jobs; trust across the project suffered as a result. Communication and information sharing reduced, there was a reduction in ‘goodwill’, and an emphasis on reporting the positive outcomes of the project above delivering the work. Finally, the end of the project resulted in individuals moving on, services being stopped, meetings no longer being attended, and organisations no longer working together. As such, some of the trust that had built up through ways of working in the project was lost, in part because personal relationships no longer existed across organisations. Notably, one historically ‘trusted’ organisation that had contributed positively in the community for many years was forced to close near the end of the project because of a lack of funding.

One voluntary sector employee I spoke to noted that as trust is recognised as key by public sector organisations, they place a great emphasis on it existing in partnership or collaborative working, even if it does not, in order to then suggest the work has been a success. Although this research has not looked at the aftermath of the WE project, in practice the signs before the project officially ended were that the NHS was moving onto the next thing for them – Integrated Care Systems and the concept of ‘Place’. This was reflected at a national level where, without any notice or fanfare, the NHS email newsletter regarding the vanguard projects changed its name from ‘The New Care Models Bulletin’ to ‘The Future Health and Care Bulletin’.

6.4.4 Trust as a Policy Goal

Finally, in relation to trust, it was seen in the project as a value in itself. This links with the idea in policy that it can be used instrumentally to suggest success – i.e. stating there was trust, even if
there is no evidence of it, suggests that any work based on that trust must have been positive.

The vagueness of trust as a concept allows for a lack of measurement of trust and therefore a lack of verifiability. It also means it is very difficult to contradict claims of trust. Trust was also given as an organisational value by participants from both the NHS and voluntary sector and it was listed as a key ‘enabler’ for Wellbeing Erewash itself (see infographic in Appendix) and for the development of work to be introduced after WE had ended, specifically in relation to ‘Place’ (see ‘Place on a Page’ in Appendix). The story of WE detailed in Section 6.2.5 also emphasised trust as having been a key aspect, with the national briefing documents noting the success in ‘trusting and empowering staff’ (Vanguard Briefing – Staff at the Heart, 2018) and the ‘Info Guides’ produced locally noting the need for trust in ‘Connecting People’ (Guide #5), ‘Identifying and Releasing Capacity’ (Guide #3), and ‘Collaborating with communities and letting people lead’ (Guide #2) – See Figure 6.1, p.187).

**Text Box 7 - Extract from ‘Learning from the Vanguards’ Document, p.7**

**INSPIRING STAFF THROUGH EFFECTIVE LEADERSHIP**

- Leaders should challenge themselves to share leadership and responsibility, as well as to prioritise talking, and listening, to staff. In Wakefield, the approach has been to trust and empower staff to make their own decisions based on what’s best for people who use services. They also opened up direct lines of communication between frontline staff and chief executives and senior leaders as they adapted to new ways of working.

This treatment of trust in practice resulted in an approach in which trust was either assumed to be happening automatically because of the enactment of policy that emphasised it – as a goal of policy - or as a result of having achieved some notion of trust at some point, that was then everlasting – such as working with communities via the voluntary sector.
Figure 6.1 - 'Top tips' extracted from WE 'Info Guides' #5, #3, #2

<table>
<thead>
<tr>
<th>Info Guide #5 Top Tips</th>
<th>Info Guide #3 Top Tips</th>
<th>Info Guide #2 Top Tips</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify what you want to change</td>
<td>Find out what the community needs</td>
<td>Listen, listen and keep listening to the people</td>
</tr>
<tr>
<td>Create clear expectations for anyone joining a new project</td>
<td>Trust people to do things differently</td>
<td>Find natural leaders</td>
</tr>
<tr>
<td>Be specific but flexible</td>
<td>Consider all demographics – the young and old and everyone in between</td>
<td>Find shared values</td>
</tr>
<tr>
<td>Tap into existing groups and communities – harness what is already out there</td>
<td>Don’t under-estimate people’s potential</td>
<td>Spend time finding out about the place and people</td>
</tr>
<tr>
<td>Be willing to co-operate with all people</td>
<td>Build relationships between sectors, organisations and individuals</td>
<td>Be patient</td>
</tr>
<tr>
<td>Give people permission and trust them</td>
<td>Celebrate success</td>
<td>Build relationships and trust</td>
</tr>
<tr>
<td>Empower people</td>
<td></td>
<td>Be reliable</td>
</tr>
<tr>
<td>Work with individuals and team – public, voluntary sector, statutory organisations</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: Adapted from ‘Info Guides’ in digital format, produced by Wellbeing Erewash*)

6.4.5 Summary of Trust

To summarise this section, trust in Wellbeing Erewash was strongly related to the personal relationships that developed both before and during the project. There was an assumption that these personal relationships were a precursor to organisational trust however in practice this relationship was not linear. Related to this, trusting relationships developed prior to the project seemed to have been an enabler initially but as the project progressed trust was eroded, particularly in relation to personal relationships that had not progressed towards organisational commitments or wider trust. The voluntary sector invested a large amount of effort in maintaining these personal trusting relationships and so their removal was particularly damaging. This was not a total surprise however as the fear of losing the progress made in the project had been expressed throughout. Despite this, the emphasis on ‘trust’ as a success factor in policy documents led to the story of the project as told through documents and evaluations also emphasising the successful development of it.
6.5 Power

The concept of power was not present explicitly in much of the data. However, as discussed in Chapter 3 – Literature Review, power is an ever present, whether explicitly acknowledged or not.

This section summarises several different aspects of power identified from the data:

- **Balancing Power** – participants at times spoke about the need to ‘balance’ or ‘share’ power, particularly with communities, and this was also emphasised in policy documents. This includes notions of the power of the NHS ‘system’.

- **Power Through Personal Relationships** – personal relationships were an important factor in the project both in how they were emphasised by different actors and how they worked in practice.

- **Power Through Funding** – several interviewees made reference to the fact the voluntary sector was funded by the public sector and that meant the sector was in a less powerful position. In practice, the way the sector was marginalised from much of the decision making around funding supports that idea.

6.5.1 Balancing Power

The notion of ‘balancing’ power was prominent in the data. Policy documents including the initial planning document for Wellbeing Erewash and later ‘Alliance Strategy’ both refer to a need to develop a balance of power between professionals and communities. This is very closely linked to notions of ‘bottom-up’ control as we shall see in Section 6.6. Communities were emphasised as the site in which this balance would be achieved and so ‘involvement’ – or the withholding of involvement – had a powerful impact. For example, the Petersham aspect of WE struggled to attract the involvement of local residents and so initial progress was slow. However, this was rationalised by the NHS as a ‘fact of life’ when trying to engage with communities, rather than a failure.

The difficulties inherent in engagement can go some way to explaining the reliance on the single community representative that was seen in the project and is discussed in Section 6.6.2., although
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they too eventually did succumb to a form of ‘engagement fatigue’. Power was invested in communities by the requirement for the NHS to consult with them. Without the authority of the NHS there would have been no context that would have enabled involvement. In this sense the power of the NHS system enabled the personal involvement of individuals, however the personal power of those individuals then in turn (re)legitimised the system.

Building on this, the voluntary sector found itself in the position of being suggested as the method by which to balance power between the NHS and communities but also holding significant power over how those communities were involved and represented. In addition, they also then found themselves side-lined by more powerful voices when individual citizens were successfully engaged, despite actively enabling their involvement in the first instance.

At times there seemed to be an absence of power in terms of decision making within the project, with named project ‘leaders’ delegating responsibility to communities and communities seeking direction from the project. Solutions to this issue tended to be found in hierarchies and structure within the NHS, such as the process of deciding sustainability funding as the project came to an end. The NHS controlled this process.

Another aspect of the power of the NHS was in the brand of Wellbeing Erewash itself. Although it was given its own identity it remained very much part of the NHS in practice, and participants identified it as being owned by the NHS. NHS employees saw this separate brand identity as offering the opportunity to ‘do things differently’ whereas voluntary sector participants did not ‘buy in’ to the same extent. The abandonment of the brand at the end of the project – the twitter account has been dormant since March 2018 and the website appears to have been taken down - suggests the ‘brand’ ultimately was not strong enough to break out of the wider NHS system.

6.5.2 Power Through Personal Relationships

As referenced above in relation to trust, personal relationships continued to be important throughout the lifespan of the Wellbeing Erewash project. In relation to power, this was not simply a case of one person or group of people having power over others in a blanket sense based on hierarchy or positional authority but varied based on who was involved and even in relation to
the subject being discussed. For example, one particular organisation was not well thought of by several people within the voluntary sector, mainly because of the relationship one key employee had with them, however, that same organisation enjoyed power over a key Public Sector worker because of a different personal relationship involving other individuals. That Public Sector worker in turn enjoyed power over the voluntary sector as a whole because of their position and felt able to direct the work of voluntary sector organisations, through their personal relationships with others in the sector. These personal influences tended to be acknowledged by other participants as a concern, however they did not express them explicitly in terms of power dynamics.

Power was also enjoyed by the single ‘community representative’ involved in the project, not least because of how they related to key individuals in both the voluntary sector and NHS. There developed a close collegiate relationship (and perhaps even a friendship) between these individuals which then impacted on how the community representative was treated and on the lack of desire shown to recruit other representative voices to the project. However, this power was not entirely owned by them as when they disengaged from the project the legacy of their involvement was used to demonstrate the success of community engagement more generally. The power of personal withdrawal was therefore not absolute as it became subsumed into wider organisational and system power.

The reliance of the voluntary sector on personal power through relationships meant that when those relationships began to fail - as noted in the section on Trust – the ways of working that had been established were unsettled. What did endure were the elements of systems and structures that were inherent in ways of working, primarily in the NHS.

6.5.3 Power Through funding

Several interviewees espoused the opinion that the voluntary sector was somehow subservient to the NHS because they were funded or ‘fed’ by them and that ‘whoever pays the piper calls the tune’ (Interviewee 17 – Public Sector Employee). This was seen as resulting in the public sector having power over the voluntary sector and adopting a ‘telling’ approach (Interviewee 61 – Public Sector Employee) that could be difficult for the voluntary sector – Erewash Voluntary Action in
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particular – to object to because of power imbalance created by the funding relationship. As one interviewee put it:

**Text Box 8 - Quote from Interviewee 83**

"I think the fact that the voluntary sector is behest to the behaviour of the statutory sector means that it will always only do what it thinks it should do to get the funding [that is] required"

Interviewee 83 – NHS Employee

However, some voluntary employees noted a different aspect to this relationship in that they experienced frustration that the NHS did not at times use its powerful position as a funder to take more control over what gets delivered and that elements of the project needed to be ‘taken in hand’ (Interviewee 10 – Voluntary Sector Employee). This amounts to an implicit acceptance of the greater power of the public sector due to its funding role. Public Sector employees rejected this notion of personal agency within power relations by suggesting they themselves did not have any personal power, and that the power was in the system of funding relations. Voluntary Sector interviewees also suggested they were slightly more detached from the project than their NHS colleagues, that there was less of a sense of ‘all in together’ or a shared culture because of their wariness of funding being cut. The implication here was that they were able maintain a certain level of independent power because of this approach. However, this did not manifest in saying ‘no’ to anything that was suggested by the NHS in relation to the project and so in practical terms it did appear as though the voluntary sector organisations were fully committed. This marked a particular difference between what was espoused in interviews and what happened in practice. This power through funding might seem to only impact on those organisations who are currently receiving funding, and grant greater power to those who are not, however many non-funded organisations either had received funding in the past or hoped to in the future and so the picture was not that simple. Of course, if an organisation had taken the decision never to apply for public sector funding again this may place them in a more powerful position, but I was not aware of any who had done so. As most of the interaction between the sector and the NHS in WE was through Erewash Voluntary Action there was very little opportunity to gather data on whether there was any difference between funded and non-funded organisations. We also have to consider that
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funding relations impact on power within the NHS as well. The ‘Acute’ services (mainly hospital trusts) both receive the most funds and are seen as the most important as they respond to urgent health issues. Some participants from non-acute NHS organisations expressed general concern over both the amount of funds acute services ‘suck up’ and the relative influence they have as a result. They therefore saw their position in WE as having less power in comparison, despite the fact that they themselves funded other organisations, often in the voluntary sector.

6.5.4 Summary of Power

The focus of the project was on balancing power and on the Voluntary Sector as the means to achieve this. However, in practice this was not achieved, in part due to the lack of capacity to proactively engage with other stakeholders. The personal relationships involved in the project that manifested trust also focussed relations of power but the breakdown in these relationships during the life of the project led to an increasing prominence for power inherent in systems and structures, notably through hierarchies in the NHS and in funding arrangements. These marginalised the voluntary sector and communities.

6.6 Control

The concept of control was referred to by participants in all areas of the project, from individuals involved as volunteers and those receiving services, to voluntary and public sector employees at both local and national levels. Often this was in the context of ‘giving up’ or ‘sharing’ control. These ideas also form a part of the national and local policy documents connected to the New Care Model Vanguards – the desire to shift control from state institutions to local organisations, communities, and service users. Many of the issues that emerged in relation to ‘control’ in the project can be associated with issues of power as described in Section 3.3.2 however I have chosen to conceptualise these under the heading of control for two reasons. Firstly, this is the term participants used to refer to the issues at hand. Use of the term therefore fits with what happened in practice and with my commitment to researching that practice. Further, reluctance to use the term ‘power’ may represent a finding in itself and a potential learning point for
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disseminating the findings of this research to practice environments. Secondly, as described in Chapter 3 – Literature Review, control can be seen as a function of power (and trust) and so my contention is that both in practice and in theory they cannot be completely separated. This will be discussed further in the following Chapter.

Four aspects of control were identified within the data (see Figure 6.2 below p.194):

1) **Top-down** – hierarchical and bureaucratic – control is from the top.

2) **Bottom-up** – ideas and influence come from individuals and communities and are embraced by others; services are adapted to meet identified needs.

3) **Middle-down** – organisations and individuals involved in practice/delivery either have control by default or as a result of their formal or informal position.

4) **Middle-up** – organisations or individuals acting as proxy for ‘the bottom’ but not formally representative of service users, individuals, or communities.

In practice, these four aspects are mixed and overlapping, rather than mutually exclusive. As such, they are presented here not as formal categories but as rubrics or heuristics that enable a conceptualisation of control in this context, and of the voluntary sector’s ability to enact control specifically. The remainder of this section will detail the data corresponding to the four different aspects of control, starting with ‘top-down’.
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**Figure 6.2 - Four Aspects of Control**

- **TOP-DOWN**
  - This includes national bodies such as NHS England and NHS Providers. It also arguably includes national voluntary sector bodies like NEF and the RSA. Locally, this includes the Leadership Team meeting but also higher levels of NHS Executive leadership and the CCG as a whole.

- **MIDDLE-UP**
  - This was mainly EVA's role in representing the voluntary sector in meetings, at events, and in workshops. In particular this included the only space for the sector on the Management Team meeting. Feeding upwards was part of running the Forums in Wellbeing Erewash.

- **MIDDLE-DOWN**
  - EVA's role in WE running the Forums and cascading information from the NHS out to the sector. This also included the role of other voluntary sector organisations in representing their users and the sector, without any formal engagement. Also touches on notions of risk and responsibility.

- **BOTTOM-UP**
  - Formal engagement with 'the community'. Formally in WE this was mainly through a single Community Representative. However, there were wider attempts to gather views through consultations and community days. The key is that views come from individuals/service users/patients/citizens.

(Source: created by author from research findings)
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6.6.1 **Top-Down Control**

This section on top-down control includes the role of NHS England, the Alliance meeting structures, and Staff Relations.

6.6.1.1 *The Role of NHS England*

It’s important to reiterate in the first instance that WE was part of the national New Care Models vanguard pilot project(s) and as such was always seen locally to be ultimately in the hands of NHS England (NHSE). This was despite NHSE being at pains to emphasise the ‘localness’ of the vanguards. This played out in several different ways in the data. All participants were acutely aware that funding came from NHS England and that each quarter representatives from WE had to justify what they had done in order to satisfy their paymasters. Conversely, the concern within the VS was the local-level funding and potential decisions of the CCG. NHSE staff did on occasion attend events ‘in the community’ in relation to WE and did acknowledge the issues of top-down ways of working. The very involvement of NHSE as an active funder drew attention to the NHS services within WE, rather than those delivered by the voluntary sector.

At times participants complained about sudden changes or new demands placed on them from NHSE, attached to continued funding. The role of NHSE within WE is not inconsistent with the general role of NHSE in terms of local influence. For example, in relation to the development and delivery of Sustainability and Development Plans (STPs), the local ‘leaders’ of this process were at times appointed centrally by NHSE. This was the case in Derbyshire albeit after several unsuccessful attempts to appoint (and more importantly keep in post) someone from the NHS in the county.

The above highlights the role NHSE had in controlling the wider agenda of the vanguard projects, including the specific financial and delivery guidance. At a local level, the NHS maintained its influence structurally over the implementation of the project through what were the MCP Board meetings and later the ‘Alliance’ meetings.
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6.6.1.2 Alliance Meetings

The ‘Alliance Leadership’ and ‘Alliance Management’ meetings became the governance structure for the vanguard in year 3 of the project. Although in a purely hierarchical sense these meetings were ‘below’ NHSE they themselves had a hierarchy locally. Discussions at the Leadership meetings were referenced in and directly drove the content of the Management meetings.

As EVA were the only voluntary sector presence on either of these Alliance meetings, the sector certainly had very little opportunity to enact any sense of control at the top of this hierarchical structure. EVA at times did feel pressure to conform to the requests emanating from these meetings.

**Text Box 9 - Extract from Field Notes - 24th April 2017**

[ Extract from Field Notes - 24th April 2017 ]

EVA Employee doesn’t feel like they could say no because they’re best placed to do it – this has come from WE [Leadership] meeting and them not knowing who is doing it – been given to [NHS Employee] and they go to [EVA Employee].

Field Notes 24th April 2017

A further emphasis in relation to the top-down nature of the Alliance Leadership meeting in particular can be found in how the meeting was run when decisions were being made about future funding. The meeting of the 13th of March was restricted to three NHS provider organisations after an email was sent at very short notice stating this was a necessary step because of tight timescales.

**Text Box 10 - Extract from Email sent to Alliance Leadership Group - March 2018**

[ Extract from Email sent to Alliance Leadership Group - March 2018 ]

Hi all,

As you’ll be aware, an Erewash Alliance Team Meeting is scheduled for [tomorrow].

In light of news relation to the procurement of Vanguard-funded initiatives and the tight timescales involved, the leadership meeting tomorrow needs to be dedicated to this instead so that [3x NHS Organisations] can discuss how services will be delivered from 1st April. Therefore, only [3x NHS Organisations] should attend tomorrow.

If anyone has any questions about this, please do let me know.

Thanks.

Email sent March 2018

The fact that the voluntary sector didn’t even have a place on this meeting highlights a double exclusion that shows how far the sector was from the decisions made about sustainability.
funding. Sector employees were aware of this exclusion, with one noting that the NHS chose when and when not to engage.

**Text Box 11 - Extract from Field Notes - 13th March 2018**

Spoke to [VS Employee] about Alliance Leadership meeting and being uninvited, [VS Employee] said that ‘they’ (the NHS) say one thing about collaboration and partnership working but then when it comes to ‘crisis’ they retreat to old/other ways of working.

6.6.1.3 Staff relations

The relations between the NHS and voluntary sector could be seen in how staff interacted around both the running and monitoring of the WE project. At times NHS staff tried to directly control voluntary sector staff and volunteers by influencing them towards their agenda, and on some occasions even went outside of organisational boundaries in relation to staff hierarchy. At one point during informal discussions an NHS employee involved with WE attempted to influence a voluntary sector employee to send a report on their ongoing delivery directly to them rather than to their own manager. This incident was later referenced in a general discussion around NHS staff identifying more with a shared WE culture, rather than as separate organisations, and having a more ‘all in this together’ type attitude in relation to staff identities and relations.

The data also highlight how NHS employees at times used EVA as a place to ‘vent’ about their working lives or current situations, to have ‘a moan’ (field notes 3rd July 2017) or for ‘support’ (field notes 30th May 2017).
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Text Box 12 - Extract from Field Notes - 3rd July and 30th May 2017

[NHS Employee] said [they were] having a moan – ‘that's today’s moan over’. Generally, it was about NHS structures and how the new Alliance/STP/Place stuff was basically going back to old PCT/Strategic Health Authority structure. [They] spoke about difficulty of working in that environment and how it would be good to say ‘it’s all shit’ if you were on the way out/retriring. [They] said [Senior NHS Employee] was good at giving them the right to disagree with/criticize policy (by example) but that it was within the context of ‘having’ to implement it even though it wasn’t great.

Field Notes 3rd July 2017

[NHS Employee] came into EVA office to have a chat.

[They] had a lot to say about frustrations about [Project Evaluation] and not feeling valued. [NHS Employee] was really venting to [VS Employee] in this situation.

[They] expressed frustration that NHS England, ECCG and others in WE all talk about Community and Personal Resilience being ‘gold’ but then don’t support it in practice or back up that way of working.

[They] also noted that people who buy into Community and Personal resilience are leaving or potentially leaving (and that they) didn’t know the new person who was leading on [work area] but [VS Employee] said they knew them and that [they were] OK – that reassured [NHS Employee].

[VS Employee] mentioned that the constant shift re: people moving and losing good personal contacts is just a way of life when dealing with the public sector and noted that the VS have experienced this for years. I noted that it can sometimes work positively as in [Example]. [VS Employee] also mentioned that aspect of bashing against a closed door as something normal for the VS.

[NHS Employee] said maybe [they were] now seeing the situation for the first time and ‘seeing that it’s shit’.

[VS Employee] reassured [NHS Employee] that they should keep working.

Field Notes 30th May 2017

The reasons for this apparent ‘venting’ are not clear from the data. However, what was clear is that in practice, NHS employees saw EVA as a place that was suitable to have such conversations, and that the organisation and the people in it would be receptive and supportive to them.

Although in this case such support seems to place EVA, and by extension the VS, as ‘above’ the NHS - they’re the ones supporting the NHS employees - it could be interpreted as another ‘service’ that EVA were offering to the NHS, free of charge and, by extension, another aspect of NHS top-down control.

In summary, the top-down elements were mainly related to the structures put in place by the NHS as part of their control over the WE project, and these tended to dominate. Despite this, elements of ‘bottom-up’ control also had a large presence within the data.

6.6.2 Bottom-up Control

All practitioners spoke about the need to work closely with local people (residents/citizens/members of the public/service users) in order to ensure services were suitable for the needs of the population. Although most participants spoke about bottom-up processes in a general sense at meetings and other events, and in interviews, examples within the data in
relation to what ‘bottom-up’ meant in practice are harder to identify. Often, policy initiatives around ‘person-centred’ or ‘asset-based’ ways of working were seen as having a ‘bottom-up’ approach implicitly, without a clear explanation of how the two aspects fitted together. The notion of ‘the bottom’ most often was used to refer to consultation and engagement with service users and general members of the public, rather than the more structural elements referred to in the meetings referenced above. This section will consider the notion of community engagement as an example of bottom-up control.

6.6.2.1 Community Engagement

In the initial planning documents for WE, and in the early stages of delivery, the workstreams of ‘Personal’ and ‘Community’ Resilience were treated separately. This involved separate meetings from the project’s initiation in April 2015 until the first joint meeting was held on the 14th of June 2016. For the voluntary sector, the Chief Executive Officer (CEO) of Erewash Voluntary Action (EVA) was listed as a ‘lead’ for the Community Resilience aspects of the vanguard but not referenced at all in minutes of the Personal Resilience aspects, the latter being led by NHS staff exclusively.

The first community events for WE took place in Feb 2016. There were two events in total, both hosted and facilitated by EVA with support from NHS employees. One of these events was held at a church community venue and one at EVA. Despite their emphasis on consultation with citizens in the community they were mainly attended by voluntary and public sector organisations with relatively few members of the public or service users present. This was a theme that would continue throughout WE, marking a difficulty that was acknowledged by various participants of reconciling the policy that called for greater community involvement with the difficulties of making that happen in practice. The community days gave rise to a saying that would become a mantra of the project: ‘people don’t know what they don’t know’. This phrase is common across community engagement work (see Civil Society Futures, 2018) however it was introduced by NHS workers, rather than from a member of the community or from a bottom-up analysis of the data collected in the session. The project also contained conflicting ideas in relation to community
engagement. On the one hand it was suggested that there was a knowledge gap amongst people in that they ‘don’t know what they don’t know’; on the other it was suggested that the way to improve services is to engage with communities that use them, along with the wider public, as they have valuable knowledge about what works and what doesn’t.

As a result of this difficulty, WE came to rely on one particular individual who had attended one of these initial community events, had been vocal in expressing their opinion in relation to the consultation that took place at the time, and had expressed a desire to continue to be involved.

The need for WE to continue to engage with ‘citizens’, coupled with the difficulties they experienced in trying to do this led to a high profile for this one individual which played out in several ways:

- They were invited onto first the MCP meetings and later the Alliance Management meetings, giving them the same position in the WE hierarchy as EVA (and therefore the voluntary sector as a whole). They were also invited to other meetings within WE such as the Health as a Social Movement (HSM) work – which they would also go on to be involved in as a volunteer – the profile they had in these meetings can be summed up by an observation captured in field notes from one of these HSM meetings:

  **Text Box 13 - Extract from Field Notes - 18th May 2017**

  NOTE: the thrill in which [Community Representative] is held by professional here. [They Are] allowed to say whatever [They] want and no one ever contradicts [Them].

  Field Notes 18th May 2017

- They were involved in planning meetings for events and workshops and in speaking at such events. For example, they were the only non-NHS speaker at the ‘Transforming Erewash’ event in September 2017 and were introduced by an NHS employee as the project’s ‘Star Citizen’. At other meetings they were referred to as ‘our citizen rep’, ‘our inspiration’ (both at a WE participation event in October 2018), and the project’s ‘North Star’ (tweeted by an NHSE employee after a visit to the project).
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- They were profiled in the WE Newsletter as the “lead public and patient representative on Wellbeing Erewash” (Newsletter 5).

- They were invited to be involved in meetings for other aspects of the WE project even when they themselves noted they did not know anything about those areas.

- They suggested possible ways that WE could develop in hand-written notes to NHS employees.

There was one other individual who at times did contribute to certain aspects of WE, but this was as an official service user representative and limited to their specific interest area. Furthermore, other specific consultations were carried out, such as with carers. These had very limited (single figure) engagement.

In practice, one single individual was primarily used as the bottom-up, community voice for the purposes of WE. It’s important to note that although EVA facilitated this individual’s involvement their relationship was not without issues. At times EVA staff found themselves arguing against that individual and in favour of wider community engagement. This was never a personal issue but a general point that wider engagement was needed as part of the WE project. As EVA were continuing to facilitate that community representative’s involvement, and they were involved in other aspects of EVA’s work, this was akin to arguing against their own service user and highlights in practice one of the tensions involved in acting as a ‘route into’ communities versus a ‘voice for’ them. In addition, the data details an instance in which the community representative objected – in a public - to EVA having their logo on materials relating to the WE project, actively questioning the legitimacy of the organisation. Further, in informal conversations the representative questioned the legitimacy any paid employee in the voluntary sector had in representing the community more widely. Despite these conflicts, which on the surface seemed to be more dramatic than any issues with the NHS side of WE, the community representative remained committed to EVA as an organisation, even after they removed themselves from the NHS side of the WE project.

The main aspect of ‘bottom-up’ control was therefore from the Community Representative, although, due to the hierarchical nature of the WE project, the potential to influence upwards
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was noted even in the relatively high-level Alliance meetings. In addition, much of the conversation around needing a ‘bottom-up’ influence was led by organisations who by their very nature were in the middle of the WE project hierarchy. The next two sections will explore this middle aspect.

6.6.3 Middle-down Control

One participant described the notion of having a single representative of the voluntary sector (EVA) and/or the community (Community Representative) as ‘middle-down’ control. This was expressed in relation to the high-profile EVA had within the project and was connected to the idea that EVA as an organisation could not represent communities as a whole because of the variety and complexity involved. This itself was an extension of the issue that EVA could not represent the voluntary sector as a whole, for the same reason. This concern over community representation came to be much more of an issue than the representation of the sector as WE progressed. It was related to the acknowledgement that the current representation within the project – i.e. having one person representing the whole community – was not sufficient. EVA employees unanimously expressed the opinion that they could not represent either the whole of the community or the whole of the sector. This concern was a constant throughout the WE project and despite the acknowledgement by most of the people involved that community representation could only happen by involving more individuals, EVA was still considered at times to be fulfilling that role.

EVA’s position in terms of representation of the community rose again when the Community Representative disengaged with the project. They also reasserted their position within WE with the production and circulation of an evaluation of their work for the project which showed a high Social Return on Investment.

EVA had control throughout in terms of disseminating information in relation to WE, both ‘downwards’ to other voluntary sector organisations and ‘upwards’ to the NHS. This included the delivery of the forums in which EVA often gave updates to attendees and organised the contributions of other organisations to the sessions. Wider engagement with the sector was also carried out through EVA; events were in their building, they often organised and administered the
events, attendees were invited based on email lists that they held, and they also more often than not were responsible for establishing the record of the meeting/event and disseminating it afterwards.

This middle-down control and the role of EVA within it seemed to be a fragile one, not just in the sense that WE was a time-limited project and that EVA did not have any additional funding to carry out the role, but also in terms of the notion identified by several interviewees that in an ideal world the NHS would bypass EVA – or any other ‘representative’ organisation – and go straight to communities. However, others suggested that because EVA were representatives of the community they could be said to be working from the ‘bottom-up’ by engaging purely with them. This mixed picture also played out in practice in how the voluntary sector, in particular EVA, were treated and their reason for involvement.

Participants were aware of the issue of having control over initiatives within the project because of the fragility of funding arrangements, however, this notion of control was again mixed with, on the one hand, a stated desire not to introduce community-led (essentially bottom-up) projects that would then disappear later on if funding was cut, but on the other working under the assumption that things would not continue without the role of the paid worker to guide the community, despite the focus being on the community delivering for themselves. This marks a contradiction and a particular characteristic of this ‘middle-down’ aspect – the espoused notion that work would be from the bottom up but the practice of the paid worker directing what would happen and what counted as part of the initiative, from the middle.

EVA’s control did not come without risk. In particular it was noted that hosting meetings and events in their own venue meant that participants attached responsibility to EVA. This led to concerns amongst EVA employees about the potential impact on the organisation’s reputation if events did not go well, particularly as at times they perceived those involved on the NHS side to be more detached, and less concerned about any potential issues. This was an example of working together but without the workload being shared. It also necessitated EVA being more assertive in the sense of deciding things for themselves, further concentrating the practice of WE
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in the middle. The control and the risk were devolved to EVA with very little reward either financially or reputationally.

For the voluntary sector then the middle in relation to WE was represented by EVA as the official representative. EVA therefore benefitted from a great deal of control over how WE was communicated and practiced with the rest of the voluntary sector. Other voluntary sector organisations were able to enact direct influence over the NHS thanks to their relationships with the local CCG however the data do not directly capture these (private) interactions. In meetings and at events these other organisations were comfortable giving a ‘sector’ opinion in their contributions, but they were not asked to play a representative role. NHS and wider public sector staff did not seem to equate their contact and relationships with ‘other’ voluntary sector organisations as engagement with the sector and/or communities in the way that their work with EVA was. This may have been driven by the policy and planning documents that named EVA as a key partner and the fact that the EVA Chief Executive was the named lead for the ‘Strengthening the Voluntary Sector’ aspect of the project.

EVA also controlled aspects of the project from the ‘middle-up’ and the next section will consider this aspect.

6.6.4 Middle-up Control

Although the role of EVA, and the voluntary sector more generally, was identified as at times being ‘middle-down’, the data also capture how they acted in a way that focussed on the middle-upwards. This was very much an inevitability, particularly for EVA, in that they found themselves between the NHS and other VS groups, particularly in relation to the delivery of the project forums. EVA, as the main voluntary sector organisation engaging with WE, acted from the middle-up in several ways.

Firstly, EVA having control of the delivery of the Forums – detailed in Section 6.2.4.1 - associated with WE was a source of control, both up and down. The forums did differ in their stated aims – as captured in their Terms of Reference (see in Appendix) – with only the Voluntary Sector Forum including any reference to influencing upwards. In practice, the Forums acted as a discussion and
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information sharing group for the voluntary sector. The fact that EVA ran the Forums, coupled with the noted theory of ‘how it could work’ meant that there was an expectation that EVA, through their involvement with the CCG, would take anything that emerged from these Forums to ‘higher level’ discussions, although this was not explicitly stated in the meetings themselves.

Other attendees of the meeting had an expectation that these Forums would provide them with information about wider changes that would have impact on the voluntary sector and their organisations in particular; that the forums would act as a link to WE and more widely the CCG generally; and that they would provide them with the opportunity to learn about the work of other organisations (see Table 6-1 below – p.205):

Table 6-1 - Reason for Attending Forums

<table>
<thead>
<tr>
<th>Answer Choice</th>
<th>Number of Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>To spread the news of the work that I and/or my organisation undertakes</td>
<td>17</td>
</tr>
<tr>
<td>To hear about other projects or work in the area which could benefit me or my organisation</td>
<td>17</td>
</tr>
<tr>
<td>To hear about other projects or work in the area which could benefit clients with whom I work</td>
<td>16</td>
</tr>
<tr>
<td>To take advantage of the networking opportunities</td>
<td>17</td>
</tr>
<tr>
<td>To keep in touch with colleagues</td>
<td>8</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td></td>
</tr>
<tr>
<td>- Responsible for the organisation of the Forum and keen for it to flourish and be meaningful for colleagues</td>
<td>1</td>
</tr>
<tr>
<td>- Support network</td>
<td>1</td>
</tr>
</tbody>
</table>

(Source: Adapted from Peter Stone Consulting, 2018, p.11)

EVA weren’t the only VS organisation ‘in the middle’ that engaged with NHS directly, other organisations operating in the local area had their own established relationships with the NHS and so had direct contracts with the CCG. This included both larger organisations engaged in contracted service delivery with the CCG and smaller organisations that had historical working relationships, perhaps through grants, Service Level Agreements, or even small contracts. These organisations did attend the Forums at EVA but also had the means to go to the NHS outside of these meetings. As such, they didn’t ‘need’ the Forums in order to have that representative voice with the NHS however primarily that direct engagement was in relation to matters other than the Wellbeing Erewash project.
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As much as organisations who attended the Forums were expected to share information, this was in relation to the delivery of their organisations, rather than the views of their service users. As such, the real ‘bottom-up’ views and opinions – engagement - was not a part of how these forums worked in practice but was filtered through the lens of the various voluntary sector organisations present. The Forums were actually bypassed in practice when information was needed from citizens, as seen when a consultation with carers was required. Upon request from NHS workers, EVA convened a separate group to discuss the issues and the work was not discussed in any of the Forum meetings.

The role of the ‘citizen representative’ was also important in relation to notion of ‘middle-up’ control as – as identified above – they were treated as the voice of ‘the user’ and of ‘the community’ despite having no membership or constituency behind their (personal) opinion. In this sense, they acted as a replacement for the testing or operationalisation of the theoretical process of the engagement with service users and the voluntary sector in relation to how the Forums could have worked. This at times put EVA and the community representative in conflict in relation to who was most legitimately representing ‘the community’. The Logic Model for the ‘Building Community Resilience’ element of WE notes the importance of working with ‘community leaders’ and people across Erewash more generally in order to engage them as ‘co-producers of service design’. The process of identifying who these people are is not described but obviously has to be controlled by someone or some organisation. As such, there was a danger of any engagement being highly selective or limited to the capacity of whichever organisation(s) is in control of the process, as was seen in practice.

6.6.5 Summary of Control

To summarise, the NHS maintained a large amount of top-down control in the project. Erewash Voluntary Action (EVA) enacted control mainly from the middle downwards to other organisations in the sector to keep them informed about the project, and upwards, acting as a representative of the voluntary sector as a whole with the NHS. Participants from both the voluntary sector and the NHS were aware that this latter function was not ideal in theory however it endured in practice.
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EVA competed to some extent with the single community representative to give a ‘community voice’ and at times this created tension. Despite these tensions, and at times palpable conflict between the Community Representative and EVA, the relationship between them endured longer than the Community Representative’s involvement with the NHS side of the project. They continued their involvement with EVA even after their disengagement with WE. Other voluntary sector organisations were not asked to play a representative role generally although they did at times give their opinions as representative of their service users and/or as the ‘voluntary sector’ as a whole. This difference was not made explicit or explored in practice.

6.7 Summary of Trust, Power, and Control

Trust, Power, and Control were all emphasised to various degrees within the data. They interacted and overlapped in the practice of the project. Notably, personal relationships were sites of both trust and power that changed over time and sat hand-in-hand with systems and structures that tended to dominate in practice. Although there was a large amount of emphasis placed on sharing control (and by implication, balancing power) in policy documents, the practicalities involved in delivery meant that despite the good intentions of participants this was generally not achieved. Of particular note is the way community representation was enacted in the project. Power was invested in a single community representative, but they were to some extent trapped in this position and unable to fully withdraw their engagement with the project even when they wanted to, due to the legacy of their involvement and the legitimacy this brought to the project. As such, they lacked control. Erewash Voluntary Action existed in the middle of the project, controlling some aspects of information sharing but unable to effect real change in the fabric of the project itself. As such, they lacked power. Although the notion of ‘control’ dominated most of the data it overlapped in practice with notions of power and at times the two terms were used interchangeably.

Another term that is related to trust, power, and control and was used extensively by participants was ‘leadership’. This was particularly emphasised in relation to the top of NHS hierarchies. The next section will consider leadership within the project and how it was enacted in practice.
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6.8 Leadership

6.8.1 Introduction to Leadership Theme

Although the concept of leadership is a difficult one to define and identify, it was one that participants in this research were comfortable using and it appears often in the data. Various elements contributed to this, including:

- The emphasis on leadership in policy relating to the NHS Vanguards, the New Care Model Programme, and in other related NHS documents.
- The existence alongside WE of a programme run by the East Midlands Leadership Academy (EMLA), to which the Chief Executive of Erewash Voluntary Action (EVA) was invited as the representative of the voluntary sector (VS).
- The overlap of different organisations and projects within and without WE that necessitated decision makers to be identified and to act.
- The hierarchical relations within the NHS, in particular including leadership of the WE project, leadership of the CCG, and the relationship between those and national leadership of the NHS through NHS England (NHSE).
- Relationships between individual participants, their ability to ‘get things done’ and the leadership emphasis placed on community representation.

This Leadership section begins with the data around the hierarchy of leadership within WE, including how EVA worked within that hierarchy. It then goes on to note the clinical influences on leadership in WE; leadership as manifested in individuals; shared leadership through relationships; leadership as skill development; and leadership as ‘getting things done’.

6.8.2 Leadership Hierarchies

In terms of hierarchy it was clear that NHS England (NHSE) were seen as the ultimate authority in relation to WE. Participants on the NHS side of the vanguard often referred to the quarterly monitoring meetings that took place with NHSE and the annual reviews that determined whether...
each year’s funding would be released. There was a large amount of emphasis on the fact that NHSE were ‘in charge’ – or rather, had control - because they were providing the money.

National bodies emphasised the role that leadership from the centre had played in the success of the project. The ‘top-down’ aspect of the Control theme explored in Section 6.6.1 identified the role of NHS England (NHSE) in influencing the work that was carried out locally. This control extended to statements specifically about the national leadership. For example, the promotional documents for the New Care Model/Vanguard programme – badged as being produced by the Local Government Association, NHS Clinical Commissioners, NHS Providers and NHS Confederation - suggest success was down to “inspiring staff through effective leadership” (‘Learning from the vanguards: Staff at the heart of new care models’, p.7) and notes that leaders should share leadership and responsibility, listen to, trust, and empower staff, and have an ‘open’ leadership structure. These nationally produced documents claimed success for national leadership.

**Text Box 14 - Extract from 'Learning from the Vanguards' Document, p.8**

**GENERATING HOPE THAT THE NEW CARE MODELS CAN BE SUCCESSFULLY DELIVERED**

- Many vanguards feel they have benefited from open leadership cultures at the national level from the arm’s length bodies, and locally, which have encouraged change and innovation and allowed staff to try new ways of working. The national bodies have sought to encourage the vanguard teams to have a go, be prepared and willing to make mistakes, and supported to learn from them. Sharing learning across sites about initiatives that go wrong as well as those that go well can help to encourage others to have a go.

However, despite claiming to have enabled more effective local leadership through “the explicit permission from the national bodies to try new things, make mistakes, and learn from them”
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(Learning from the vanguards: Spreading and scaling up change, p.1), NHS England at the same time were being accused of imposing their will in other ways (Alderwick et al., 2016).

As the WE project came to an end the sustainability and funding decisions became the remit of the local CCG and with that came ultimate authority and hierarchal leadership – they made the decisions in the absence of the voluntary sector who did not have a place on the Leadership Team meetings.

The voluntary sector also had accountability towards national voluntary sector organisations (RSA, Nesta) through the Health as a Social Movement (HSM) - Community Connectors – work detailed in Section 2.7.4. Although those national organisations oversaw the HSM work, they did not have a say in how money was spent locally – this was decided by the CCG – however they did have the authority over both voluntary sector and NHS workers locally to influence the direction of the work. This included several workshops and meetings aimed at developing the notion of ‘social movements’ within the project. The involvement of these national voluntary sector organisations created something of a hierarchy within the voluntary sector as in practice Erewash Voluntary Action workers often deferred to NEF or the RSA in how the sessions for HSM were run and had to contribute reports to them in order to update on progress. In addition, NEF had a high profile at certain WE events - notably the ‘Transforming Erewash’ event on the 28th of September 2017, at which they - rather than a local organisation - presented an update on the work.

Although in theory NHSE and other national organisations, along with Erewash CCG, were reliant on local organisations to work in a ‘bottom-up’ or ‘community focussed’ way in order to legitimise the approach the project had taken, we have seen (in Section 6.2.5) how the story of WE was written without much acknowledgement of what happened in practice. As such, even if in theory this provides a greater leadership role for organisations and people outside of hierarchical positions, the official account does not recognise them.

Identifying the ‘top of the leadership tree’ did not automatically mean others were clear on how leadership worked in this context. One public sector attendee at the Management Team meeting on the 26th October 2017 noted that those present could be more active in making decisions as “we know we’re paralysed through leadership”. This idea of a ‘lack of leadership’ was noted by
other participants, particularly in relation to ‘higher level’ aspects of local service delivery, such as the “vacuum of leadership” described by one attendee at a Leadership Team meeting in February 2018. The implication here being that the Leadership Team itself could fill that vacuum by asserting its leadership role in the wider NHS system. This notion of an absence of leadership became more apparent as the project came to an end but wasn’t always treated as a negative. One meeting participant speculated that their lack of knowledge about what was ‘going on’ was a result of ‘better leadership’ in that someone else was worrying about it.

**Text Box 15 - Extract from Field Notes - 3rd October 2017**

[NHS Employee] noted not knowing as much as about the vanguard at the moment, [They] speculated that this is because [NHS Colleague] is more competent than previous and because their “leadership” (her word) is better.

Field Notes 3rd October 2017

In addition, the workstream meetings developed a sense of some ‘other’ that was making decisions in relation to sustainability. The secretive nature of sustainability discussions may have influenced this.

Data also played a role in how leadership worked towards the end of the project, particularly in relation to sustainability discussions. There was a large amount of emphasis placed on both getting data that could prove effectiveness and then presenting that data in the right way. Notably this was mainly from the NHS point of view as evaluations produced by the voluntary sector that showed very positive data were mostly ignored – as identified in Section 6.2.3.

### 6.8.2.1 EVA in the Hierarchy

EVA was the named lead organisation in relation to the ‘Strengthening the Voluntary Sector’ aspect of the project and in practice this meant that any engagement of the voluntary sector in the project invariably went through EVA. Notably, in official documents it was often the Chief Executive Officer (CEO) who was listed by name as the lead, rather than EVA as an organisation. However, as Section 6.8.4 will show, the EVA CEO was often referred to in relation to their voluntary sector role only, rather than any official role they had within the WE project.
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In addition – as noted in Section 6.6.1.3 - NHS employees tried to influence the work of EVA staff who were not directly under their control. Equally, there was an expectation from EVA that other aspects of WE would be ‘taken in hand’ if they did not perform, suggesting that they were happy with this leadership dynamic to some extent.

EVA’s position as being named as responsible for ‘Strengthening the Voluntary Sector’ and being the lone voluntary sector representative at various meetings, plus their position as ‘conveners’ of Forums, meetings, and events was part of the overall hierarchy of WE. As noted in Section 6.6, they found themselves somewhat ‘in the middle’ of WE, liaising between the NHS (above) and the wider voluntary sector/communities (below). This position at times created tensions in attempting to meet the expectations of these two areas of accountability, which also had to be balanced against internal priorities. This was particularly noticeable in relation to the ‘Quality for Health’ (QfH) element of WE.

6.8.2.2 Quality for Health

Quality for Health (QfH) is a ‘kitemark’ developed by Voluntary Action Calderdale (VAC) aimed at providing assurance to NHS commissioners that voluntary sector organisations bidding for work are of sufficient ‘quality’ to be able to deliver (see www.qualityforhealth.org.uk for more information). EVA were designated by the CCG as the lead organisation for delivery of the QfH initiative in Erewash. Various issues impacted on their ability to deliver this work, including:

- An initial suggestion by the CCG that achieving the kitemark would be a requirement to secure future funding was not followed through in practice, meaning that a major incentive to achieve QfH was removed.
- EVA found the burden of training and support for applicants more difficult than anticipated. This included having to remodel their materials after the QfH programme was changed by VAC. This was time consuming and resulted in wasted resources.
- EVA went through the accreditation process themselves and found the effort it took to be substantial. I carried out much of the collating work for this during my time with the
organisation and can attest to the time-consuming nature of it. This gave EVA pause in recommending QfH to smaller organisations with even less capacity.

- Feedback from applicants was mixed at best. Some were positive, suggesting the work had given them more focus, whilst others were negative in relation to the time and capacity needed to complete something that didn’t seem to have any real benefit in practice. It did not help that some of the first organisations to sign up for QfH actually had their funding cut or removed by the CCG.

Despite this lack of success, nothing negative was reported officially in relation to QfH and there were suggestions informally that it ‘couldn’t be seen to fail’ as it was in some ways the ‘flagship’ link between the voluntary sector and the NHS in Wellbeing Erewash. It was also suggested by some participants that this pressure had led to some ‘fudging’ of evidence required to achieve the quality mark. Officially, the benefits of QfH continued to be emphasised until the end of WE and it was included as part of three elements of ‘Building Partnerships’ as part of the ‘Insight Guides’ produced at the end of Year 3 to promote what had been successful. EVA were faced with a difficult decision in continuing to promote something that they had been paid to deliver, despite knowing that it may not have been suitable for their members or the wider voluntary sector. EVA could point to some benefits identified by participants, in addition to the training materials that they had developed as reasons to continue delivery, but the ongoing support for it appeared to be a rationalisation rather than based on a real evaluation of impact.

Within QfH therefore, EVA had a large role in terms of hierarchy, both in the sense of being the organisation funded to deliver it and also in terms of leading the voluntary sector to apply, train for, and produce, their submissions for the quality mark. EVA also had a leadership role to play in legitimising QfH by continuing to support it, even in the face of the above acknowledged frustrations. Of course, the fact they were funded to deliver this by the CCG meant that any decision to cease delivery may have resulted in financial penalty and/or a loss of face.
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6.8.3 Clinical Leadership

The Health and Social Care Act (2012) and the Clinical Commissioning Groups that resulted from it gave a much greater role to clinicians – notably GPs - in the leadership of local health care services, including decision making around funding. This was also reflected in how WE worked both in the position GPs had in the running of the project and the ultimate decisions made in terms of funding and sustainability. Notably this was dominated by considerations relating to the ‘Primary and Integrated Services’ aspect of the vanguard, but also had an effect on the ‘Community and Personal Resilience’ workstream in which the voluntary sector primarily operated. The sustainability reports for WE – produced by an NHS employee with responsibilities in both the WE project and wider CCG, in conjunction with those delivering the different project elements, including the voluntary sector – were addressed to the CCG and decisions regarding sustainability were made by them. This included adapting some of the funding requirements for previous work in order to justify ongoing spend, most notably in altering the Health as a Social Movement ‘Community Connectors’ role to be focussed more on ‘Social Prescribing’ within GP surgeries, in order to satisfy the demands of the ‘General Practice Forward View’ (NHS, 2016k).

Individual GPs had high profiles as Chair of the CCG, Chair of the Leadership Team meeting and as ‘Clinical Advisor’ to the WE project. GPs were noted as “essential leaders” at the Leadership Team meeting of the 14th November 2017 and the profile of GPs was pushed in WE documents. For example, the WE newsletter contained an interview with the Clinical Lead who stated:

Text Box 16 - Quote from Wellbeing Erewash Newsletter, #6, p.10

"The voice of the GPs within the MCP (multi-specialty community provider) is strong and it’s respected by the other providers. The leadership team contains a number of GPs and all other providers feel it needs to be led by general practice”.

Wellbeing Erewash Newsletter, #6, p.10

Additionally, the 2016/17 refresh of WE ‘Value Proposition’ document noted “Excellent clinical leadership” as the unique selling point of the project.
However, other data suggests this may not have been true in practice, certainly not consistently.

GP attendance at WE meetings tended to be confined to the Leadership Team – which it has been identified previously mainly dealt with the ‘Primary and Integrated Care’ aspects of WE - and as a result their direct influence elsewhere was not apparent. GPs very rarely attended the ‘Community and Personal Resilience’ workstream meetings, or the community/engagement events with the community. Furthermore, one interviewee actually noted the lack of GP involvement as a ‘good thing’ in WE as compared to other areas they had worked in. As much as GPs had a high profile, they also faced criticism from other parties; during one of the East Midlands Leadership Academy sessions an attendee referred to GPs acting ‘like children’ and suggested they were ‘stubborn’ in dealing with other partners in the local area. The draft WE Evaluation Report (based mainly on interviews with NHS workers) noted that there was general positivity around senior (and therefore, clinical) leadership in WE but also that there had been some issues, mainly relating to continuity.

6.8.4 Leadership as Individual

The notions of leadership as hierarchical were often accompanied by the related notion of leadership as individual. For example, the RSA work on Health as a Social Movement (HSM) asked in one meeting with NHS and EVA staff if they could identify ‘systems-focussed local leaders’ who would be able to influence the local agenda. As might be expected based on the previous section, those present suggested a local clinician - a GP. We can also see the emphasis on individual leadership in how NHS staff introduced themselves as ‘leads’ for different elements of WE. This extended to ideas about what the ‘right sort’ of leadership was and often individuals spoke about needing more of the ‘right sort’ of leadership within the WE project. This did not seem to be
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referring to any particular individual or even a specific definition or set of skills. At other times specific individuals were referred to, including the CEO of Erewash CCG, who was seen as having been crucial in the early days of WE but who had left at the beginning of year three due to staff restructuring. Other individuals referred to as leaders included the Chair of Erewash CCG and the incoming ‘Accountable Officer’ for the CCGs in Derbyshire.

As noted previously, within the structure of WE itself, certain individuals were officially named as ‘leads’ for specific elements of the project. These were entirely NHS staff, apart from the work aimed at ‘Strengthening the Voluntary Sector’ for which the Chief Executive (CEO) of EVA was named as the lead. However, despite this seeming equality of designation in relation to the project, the CEO of EVA was very rarely referred to in relation to their ‘leading’ role in part of the WE project, and more often than not was referred to as ‘the Chief Executive of EVA’. In comparison, the NHS employees within WE were referred to in relation to their position within the project, rather than their substantive organisational roles. In addition, as ‘Strengthening the Voluntary Sector’ was part of the ‘Community and Personal Resilience’ workstream of WE, it was subsumed within the remit of the NHS employee named as ‘lead’ for this aspect. This particular employee always introduced themselves at meetings and events as ‘leading the’ or ‘the lead for’ the Community and Personal Resilience work. In contrast, the Chief Executive of EVA very rarely referred to themselves as ‘leading’ the ‘Strengthening the Voluntary Sector’ element.

The EVA Chief Executive, and other voluntary sector employees, would often be given actions and responsibilities in relation to WE that seemed to be more relevant to the NHS ‘lead’. For example, the ‘Sustainability Report’ for the HSM work detailed the owner of every action as an EVA employee, despite that fact that some of the actions referred to funding, something the voluntary sector had no control over. Further evidence of this can be seen in an informal action plan developed between voluntary sector and NHS workers dated the 6th of April 2017 in which of the sixteen actions listed in relation to the whole of the Community and Personal Resilience workstream the voluntary sector – through EVA - was named as fully or partly responsible for eleven of them and in only one area were they not listed as having any responsibility to take

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action. At times, NHS workers not only expressed a leadership identity but also described what was expected of them within those roles:

**Text Box 18 - Quote from Interviewee 53**

“**So, my job at the moment is working out where the impact is attributed to, so, what are the bells? What are the whistles? What can we strip away and say: ‘without that we will still have all of this wonderful impact for the benefit of citizens...’**”

Interviewee 53 – NHS Employee

This espoused opinion suggests quite a powerful role in relation to decision making within the project. It is reflected in practice by that employee acting as Chair of the Alliance Management Meeting and managing the attendance at the Alliance Leadership Meeting.

Notions of individual leadership can also be seen in how the Community Representative was referred to and treated within WE. As noted previously, they were venerated as the project’s “Star Citizen” and “North Star” and in meetings their opinion was generally treated with a great deal of respect. However, it was less clear whether that person’s voice translated into an influence on decision making that affected the WE project as a whole. In contrast to the positive light in which the Community Representative was painted as a leader, NHS employees at times expressed that being a ‘leader’ in their organisation was not a positive experience, mainly due to the pressures on the NHS as a whole.

### 6.8.5 Relationships and Sharing Leadership

From the earliest community events it was clear that the key relationship in terms of the delivery of the Community and Personal Resilience aspect of Wellbeing Erewash was the one between the Chief Executive of Erewash Voluntary Action (EVA) and the Community and Personal Resilience workstream lead for the NHS. They worked very closely throughout the project, often attending the same meetings and planning events, workshops, and community days together. They both also enjoyed a close relationship with the WE Community Representative. This continued until the Community Representative disengaged with the project, at which point the relationship with the EVA Chief Executive continued but the one with the NHS worker did not. This did not appear to be because of any personal issue but rather because of the professional relationship ending.
The close working relationships translated into a shared responsibility and shared ways of working in relation to WE. This manifested in different ways, including:

- A personally supportive relationship – the workstream lead would often either ring the EVA CEO or come into the EVA office to chat about the WE project generally. At times this seemed to be ‘unloading’ frustrations with a sympathetic colleague and at others was focussed on progressing the work of the project.

- Although the NHS worker was the official or ‘named’ lead for the Community and Personal Resilience workstream, they were often jointly listed as responsible for agenda items and updates in meetings, with the EVA CEO. For example, the workstream meeting of the 14th December 2017 listed 8 agenda items, of which the NHS workstream lead was listed as ‘lead’ for 3 and the EVA Chief Executive as ‘lead’ for 3 (the other 2 ‘leads’ were other public sector workers).

- Conversations and meetings were ongoing constantly between the two in relation to the practical aspects of WE and this included the creation of a joint ‘Action Plan’ that to my knowledge was only shared between them.

- Both were involved in arranging events and meetings, with both also involved in presenting information at those meetings.

- Follow-up from meetings and events was also shared between the two. For example, EVA took the lead on collating information from the ‘Storytelling’ workshop in January 2018 but the NHS workstream lead created the first version of the ‘Erewash Story’ in February 2018.

- As much as the voluntary sector were restricted to levels below the highest meetings (the MCP Board and later Alliance Leadership Team) the Personal and Community Resilience lead was also not present at those meetings. This was a shared limitation.

- The two ‘got on’ on a personal level and also seemed to have a similar idea about what the project was for even if it was not articulated explicitly between them – at the very least they both seemed to think the other thought like they did. However, they didn’t ever specifically explore whether this was true or not.
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The notion of a shared understanding or identity extended to something of an ‘us versus them’ mentality for staff involved with the project, particularly in relation to how NHS employees saw their roles in comparison to their organisational colleagues.

6.8.6 Leadership as Skill Development

Related to leadership as an individual phenomenon in WE, there was a specific focus alongside the project on developing leadership skills. For example, ‘leadership’ was referenced extensively in relation to the ‘Brilliant Erewash’ element of WE. Specifically, this was about developing young leaders in schools in order to improve their confidence, resilience, and approach to mental health. The idea being that those trained as part of the programme would then act to cascade their learning and act as a resource for their peers. The project focused on using “young people’s leadership as the tool for transformation” (Newsletter 8).

A significant aspect of leadership within WE, particularly as it relates to the voluntary sector, was the leadership course run by the NHS East Midlands Leadership Academy (EMLA) during 2016/17. Key as regards the voluntary sector in relation to the EMLA programme is that they were invited to have a place on it, alongside NHS staff. This place was offered to and taken by the Chief Executive of Erewash Voluntary Action. As the rest of the attendees at the EMLA sessions were Local Authority or NHS employees, this marked a rare and significant opportunity for a voluntary sector voice to be present alongside the learning and professional development of public sector staff, something that participants remarked upon as unusual and welcome. The EMLA sessions were mainly aimed at developing leadership skills through the teaching of various approaches to leadership over the course of several sessions and a role-playing scenario as part of an all-day training event.

Much of the formal teaching aspect of the EMLA sessions focussed on different types of leadership including: ‘Transactional versus transformational leadership’ – Figure 6.3 on p.220 was used to show the differences between these two types of leadership, and this prompted some discussion around the need to engage more with ‘hearts and minds’ in the NHS.
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Figure 6.3 - EMLA Transformational Leadership

The EMLA tutor also gave an overview of the ‘5 Stages of Tribal Culture’ and invited attendees to reflect on where they sat on it, along with where others in their organisation did – see Figure 6.4 on p.221.

(Source: extracted from EMLA, 2017, image © Sonia Sparkles, see: www.soniasparkles.com, used with permission)
Leadership ‘styles’ were also discussed, and it was proposed that there were six styles that are suitable for different contexts – see Figure 6.5 below (p.221).

*Figure 6.5 - EMLA Leadership Styles*

This image contained details of the ‘6 Emotional Leadership Styles’ used in a presentation by the East Midlands Leadership Academy. The concept originally appeared in the book ‘Primal Leadership’ by Goleman et al (see: http://www.danielgoleman.info/topics/leadership/). The original image can be found here: https://www.slideshare.net/pccampo/leadership-models

(Source: extracted from EMLA, 2017)
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There is a clear emphasis on behaviour in all of these models and they were presented in a way that suggested attendees could aspire to develop themselves by embodying these behaviours. This emphasis on leadership as a personal ‘thing’ was further reinforced in a discussion about ‘good’ leaders. No voluntary sector elements were discussed in relation to what ‘good’ leadership might be, or where attendees should look for inspiration and advice to become ‘better leaders’. However, EMLA attendees who were interviewed tended to note the value of having a voluntary sector point of view in the room as one of the main advantages of attending, alongside having the time to share information and to talk to others about the stresses and strains of their jobs. The specifics of what was taught were rarely mentioned.

Despite these positive espoused opinions regarding the value of the voluntary sector, much of the documentation produced as part of WE downplayed or did not mention the sector at all.

However, in practice, the voluntary sector – and EVA in particular – played a significant role in ‘getting things done’ in the project. The next section will consider this aspect of leadership.

6.8.7 Leadership as ‘Getting Things Done’

As with any complicated project involving multiple organisations and interests, a lot of work was happening in WE at any one time. The data in this research are mainly limited to the work in the Community and Personal Resilience workstream of the WE vanguard because this is where the voluntary sector was involved. This aspect of WE contained a lot of ongoing work, often performed informally or ‘under the radar’ by EVA, but also by NHS staff. The focus of this thesis is on the voluntary sector’s contribution and this was primarily through EVA. As much as this work can be categorised as ‘getting things done’, it could also be suggested that it is valuable as much for ‘stopping things being done’ in the case of duplication or unneeded expense.

EVA worked in several different ways in order to get things done in the project, including:

- Employing the worker for the Health as a Social Movement element of WE. It was suggested by participants from both the NHS and from EVA that this had happened because EVA were more flexible around advertising, employing, and supporting a new worker to get involved quickly in delivering the work. It was thought that going through NHS processes would have
been too complex and time/resource consuming to make what was a one year post viable.

The success of this – getting the individual in post and delivering results – was a large positive in terms of EVA’s work in the WE project and later a similar arrangement was negotiated for a worker funded through money from the Local Authority.

- This additional flexibility extended to the approach of EVA to funding. Notably in WE this included administering the Forums and contributing to other aspects of the project – in particular, staff time to attend meetings and events – without any direct funding to do so. This was an ‘in kind’ contribution delivered by EVA whilst their overall funding – through which they ‘covered’ their work as part of WE, and which was paid for in part by Erewash CCG – was under review. It was noted in the ‘Sustainability Report’ for the project produced by the CCG, that delivery would be dependent on a continuation of EVA’s ‘core’ funding.

Nevertheless, a significant amount of time and effort was put forward by EVA staff without any direct financial funding or reward, and no additional funding was requested to carry the work forward. EVA also attempted to proactively work with public sector partners to offset funding cuts, such as suggesting to the Local Authority that they should be able to sell spare places on a training course they were paid to deliver to make up for a cut in funding.

- EVA also prevented the CCG from spending money when they did not need to. This notion can be applied to the entire project as EVA were involved initially as an alternative to commissioning an outside consultancy, as shown in the initial planning documents for the project. A specific example within WE is the work with carers. Instead of setting up an entirely new element of work to support carers, the contacts EVA already had with groups enabled consultation to take place and work to be taken forward based on the needs identified with carers themselves (although there were limitations, identified previously in Section 6.6.2).

- The role EVA played in distributing information has been emphasised previously but cannot be understated. The ‘Evaluation Report’ for EVA’s work in the project captured the value of this, including the networking that took place within the Forums. This work created a sense of engagement and groundswell of support for the project amongst the wider voluntary sector.
• EVA also worked with other voluntary sector organisations on new and ongoing initiatives. 

The data capture this in relation to a ‘Men in Sheds’ project to support mental health. EVA initially hosted this project in their offices in order to get it ‘off the ground’ but then worked with another local voluntary sector organisation to transition the project to their control, whilst continuing to support the project’s volunteers. EVA also worked to support other aspects of WE that were being delivered by different organisations. An example of this is EVA’s involvement with the Community Sports Trust (CST) to support work in the Petersham area of Erewash. EVA shared some of the planning and workload, particularly in relation to the early consultation events with the local community.

At times, EVA worked in what could be described as ‘manipulative’ ways in order to get things done. This happened at three different levels and with correspondingly different motivations:

1) **Work aimed at benefitting the organisation itself** – this included noting the need to influence other individuals within the WE project towards EVA’s ‘way of thinking’. This was justified by EVA as a response to more nefarious influences from other organisations and individuals, rather than a singularly selfish motivation from EVA itself.

2) **Work aimed at gaining a positive influence for the WE project** – this was particularly noticeable when new senior workers came into post in the public sector. EVA used their professional and personal links to gain access to individuals – such as the new ‘Place’ lead – and promote the project. However, this work was largely ignored or actively dismissed by NHS individuals within the project who maintained hierarchical leadership positions.

3) **Work aimed at gaining influence and support for the whole of the voluntary sector** – this was mainly around leveraging links with commissioners of services in order to persuade them to either invest more in the voluntary sector as a whole or to maintain their current investment in services. It was seen as a normal part of EVA’s role in the sector and extended to working in practice as an advocating voice in meetings and at events. This can be seen in the structure of the Voluntary Sector
Chapter 6 Findings

Forum – EVA were expected to contribute on the Forum’s (and therefore the voluntary sector’s) behalf to strategic discussions with the public sector.

This is not to say EVA was perfect as an organisation generally, or in relation to leadership specifically. At times there were internal tensions amongst the staff in relation to a variety of different issues - as would be expected of any organisation - and these were sometimes expressed by participants as relating to ‘leadership’. Equally, there were times when what EVA suggested was ‘best practice’ to their members did not quite match how the organisation itself worked. In addition, EVA also experienced conflict at times with other organisations, including other voluntary sector organisations. The data detail far more conflict within and between voluntary sector organisations than with the public or private sectors however, much like the conflict experienced with the Community Representative, this never led to a breakdown in relations.

Finally, in relation to EVA, it was expressed by some staff that they worked – and by extension the voluntary sector worked – to support people in society who were more vulnerable or who had been ‘forgotten’. This was reflected in practice with EVA staff delivering direct services – such as the shopping project, befriending, transport, or volunteering (see Figure 2.9 on p.34) – and in going ‘above and beyond’ in relation to their responsibilities towards clients, something that is not uncommon in voluntary sector organisations (Hardill and Dwyer, 2011). This manifested in EVA workers chasing additional information about client referrals, and, in particular, attempting to find clients who went missing. Often this was because they had been admitted to hospital, but EVA staff took it upon themselves to find out where they had been admitted, what for, and when they would be discharged. They also then cascaded that information to workers in other – often public sector - organisations that they knew were in contact with that particular individual. This again highlights the crucial role EVA played in sharing information.

6.8.8 Summary of Leadership Theme

To summarise, leadership in the context of WE was complex. In policy and espoused opinions, much of the talk was of collaborating and sharing leadership with others but this was couched in
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the explicit hierarchy of the NHS and a suggestion that higher levels of the organisation, and in particular clinicians, should be responsible for leadership and leading. In practice, much of this hierarchy was visible and impacted on how the project was run. However, within this hierarchical way of working there was a definite – although largely unsuccessful – attempt to share and widen the notion of leadership. The EMLA course introduced other conceptualisations of leadership and there were examples of individuals and organisations – particularly EVA - informally ‘getting things done’. Relational aspects between individuals were also important, particularly between the NHS ‘Community and Personal Resilience’ workstream lead and the EVA CEO. Erewash Voluntary Action had a large role to play in the more informal aspects of leadership working both to support the project and at times to manipulate it.

6.9 Summary of Findings Chapter

In conclusion, the above has detailed the key aspects of the findings of this research. The first section detailed the ongoing gap that exists between policy and practice, despite the good intentions of both policy makers and practitioners. The voluntary sector was notably missing from key aspects of the project and was not listed in documents as an official partner of the project. Furthermore, what engagement there was with the sector was through one organisation – EVA – and often one individual – the EVA Chief Executive. EVA in turn had responsibilities to both represent the sector and wider communities and provide a route into them in order to gather additional points of view and encourage engagement. At times these responsibilities conflicted and stretched the capacity of the organisation.

The second section explored the interacting elements of trust, power, and control. Personal relationships played a notable role in practice but were impacted by time in different ways. Trust seemed to decrease whilst distrust increased over time as these relationships changed. This revealed the dominance of structures and processes, particularly in the hierarchy of the NHS and highlighted a lack of personal power amongst NHS employees. The policy goals of ‘sharing control’ and moving towards more ‘bottom-up’ control mechanisms were not achieved in practice. EVA had a role in the overall hierarchy of the project – often in the middle of this control function –
but little real power to make decisions. There were tensions between notions of representation of individuals and communities in the data created in particular by the reliance on a single community representative. Although they appeared to have a powerful position in the project, this was invested in them by the structures and processes of the NHS. This is highlighted in that the legacy of their involvement continued to give the project legitimacy, despite the fact they had withdrawn from it.

Finally, although much of the project seemed to conform with hierarchical notions of leadership – which often excluded the voluntary sector – and focus on leadership as an individual behaviour or skill that could be developed, there were significant aspects of relational leadership at work and attempts to share leadership responsibilities. The voluntary sector – EVA in particular – were able to enact leadership within this context, mainly by ‘getting things done’, outside of hierarchical structures.

Overall, the leadership context of the Wellbeing Erewash project was complex and contained a mesh of interacting practicalities as would be expected in any collaborative environment (Huxham and Vangen, 2005; Crosby and Bryson, 2014).

The following Discussion chapter will build on the findings presented above and explore them in relation to the literature presented in Chapter 3 – Literature Review.
Chapter 7. Discussion

7.1 Introduction to Chapter 7

The previous chapter detailed the findings of the research that emerged as a result of following the inductive research design detailed in Chapter 4. This included the ongoing gap between policy and practice in the project; how the voluntary sector was missing from key aspects; the dominance of NHS hierarchy, particularly in relation to clinical professionalism; and how Erewash Voluntary Action was expected to act as both a route into communities and a voice for them, often in competition with the community representative. The findings also detailed the interacting elements of trust, power, and control, particularly in relation to the emphasis on community engagement and ‘bottom-up’ aspects, in contrast to the ongoing hierarchical, funding, and convener power of the NHS. Finally, the findings detailed how leadership worked in the project, particularly in relation to the impact of ongoing leadership hierarchies, links with personal relationships, and the ability of the voluntary sector to ‘get things done’.

This Discussion chapter serves to explore the findings of the research in light of the literature detailed in Chapter 3 and to identify the contribution that the thesis makes. Firstly, I will discuss the role of the voluntary sector - Erewash Voluntary Action (EVA) in particular - in the Wellbeing Erewash (WE) project as a continuation of aspects of both New Public Management (NPM) and New Public Governance (NPG) ideals, exacerbated by the current austerity context in the UK. In particular, this will focus on the fact that the voluntary sector was missing and/or excluded from key aspects of the project in practice, despite a large emphasis on their importance in both local and national policy documents, and in the espoused opinions of research participants. These findings reflect ongoing literature around the voluntary sector’s role as a junior partner to the public sector in terms of collaborative service delivery (Milbourne et al., 2003; Macmillan, 2010; Rees et al., 2012; Milbourne and Cushman, 2013; Munro, 2018), particularly in relation to the NHS (Rees et al., 2016). A key aspect of this in WE was the NHS role in acting as both convener and funder and the power and control over the project that they had as a result. This also meant the
voluntary sector faced a large amount of pressure to be involved within the project in at times conflicting ways, particularly in relation to their role as ‘transmission belt’ organisations (Albareda, 2018). My research builds on Albareda’s quantitative research that focussed on voluntary sector policy influence, to detail how the role of a transmission belt organisation works in practice within a collaborative approach to service delivery. For Erewash Voluntary Action in particular this created an additional tension alongside the accepted unity/diversity issue that voluntary sector infrastructure organisations confront.

Secondly, I will discuss how the practice of WE reflected different traditions of personal/system trust and power within both the NHS and voluntary sector and how a focus on control within the project served to mask these different traditions, ultimately leading to the failure of attempts aimed at moving towards more ‘bottom-up’ ways of working. These aspects were manifested in the personal relationships between different participants, the power enjoyed by the NHS as convener/funder, the untested engagement structures within the project, and the lack of the power to withdraw experienced by the community representative. Ultimately, a failure to address these different traditions serves to further entrench existing power imbalances. This finding adds empirical evidence to the existence of unique characteristics within the voluntary sector, helping to break down the notion that such suggestions are ‘mythical’, as some writers have claimed (Knapp et al., 1990; 6 and Leat, 1997; Kendall, 2003).

Finally, I will discuss the complexity of leadership in the project and in particular the dominance of national and local NHS – notably clinical - hierarchies. EVA had a place within this hierarchy as the named lead organisation for the voluntary sector and so were at least to some extent complicit in reinforcing it. However, having a named lead organisation outside of the NHS does represent an attempt to share aspects of leadership and this sharing was also seen in aspects of leadership manifested in individual relationships in WE, particularly between the NHS programme lead and the Chief Executive (CEO) of EVA. Despite this, there was also an emphasis on the role of certain individuals as ‘leaders’, particularly the single community representative, however this role was invested in them by the project – and therefore the NHS. The voluntary sector – through EVA –
enacted leadership in different ways both within the WE project and outside of it. They were able

to ‘get things done’ within restrictions that they were aware of but resigned to.

### 7.2 The Role of the Voluntary Sector in Wellbeing Erewash

Section 6.2 of Chapter 6 – Findings, detailed the gap between policy and practice found in

Wellbeing Erewash (WE). Specifically, this included the difference between the emphasis on the

sector seen in both national local policy and planning documents, and in the espoused opinions of

research participants, when compared to what happened in practice. Nationally, the voluntary

sector were described as ‘key partners and enablers’ of the New Care Model Vanguard projects

(see Figure 2.4 on p.22); locally, Erewash Voluntary Action (EVA) and other voluntary sector

organisations had relatively high ‘influence ratings’ in early planning documents - the same level

as GP practices and higher than other stakeholders such as the education sector and the media.

EVA was also named as the ‘lead organisation’ for the ‘Strengthening the Voluntary Sector’ aspect

of the project. However, the findings also detailed the assumptions that fed into why the

voluntary sector was seen as so important – because it was seen as better able to identify and

support the needs of ‘the community’. This suggests the voluntary sector in WE was used for a

specific purpose, in an instrumental sense, rather than for any general contribution to the running

of the project as a whole. As Section 6.2.3 shows, the sector did not have a place on the

‘Leadership Team’ that developed during year three of the project. In addition, no voluntary

sector organisation was listed as an official ‘partner’ of the project.

As mentioned in Chapter 1 - Introduction, this gap between policy and practice is not a new

finding in relation to voluntary-public sector collaboration. The work of Linda Milbourne and

colleagues in particular has highlighted this over the last two decades (Milbourne et al., 2003;

Milbourne and Cushman, 2013; Milbourne and Murray, 2017a). However, what this research has

lacked is a detailed account of the experiences of the voluntary sector in practice and that is what

my research provides. In this section I will discuss three areas relevant to the role of the voluntary

sector: the position the NHS had as convener of the project; the role of Erewash Voluntary Action

as a ‘transmission belt’ organisation; and the potential for the demands placed on the sector to

‘kill the golden goose’ that is the voluntary sector’s link with communities.
Chapter 7 Discussion

7.2.1 NHS As Convener

The findings detail how the NHS enjoyed a powerful position within the Wellbeing Erewash (WE) project in relation to how the voluntary sector was involved (Section 6.2); the interactions of trust, power, and control within the project (Sections 6.4, 6.5, 6.6); and in relation to leadership, particularly leadership hierarchies (Section 6.8.2). The project itself was collaborative and as such the collaboration literature offers some insights as to why the NHS enjoyed such a position. Gray (1989) suggests that whichever organisation convenes a collaboration is likely to have a position of power as they are able to dictate (at least in the first instance) the direction of any work that is delivered. This is amplified if the organisation is also the funder of the project, as the NHS was for Wellbeing Erewash. The NHS therefore was able to define the success factors of the project at the start and also ‘write the story’ of it at the end. ‘Story’ here refers to the literal story of the project as described in Section 6.2.5. Crucially, none of the documents produced that told this story included negatives or difficulties inherent in collaborating, the areas the voluntary sector was excluded from, or the relative failures of the project. They also emphasised the way that trust was achieved within the project, treating trust as a policy goal as detailed in Section 6.4.4. This appeared to be primarily a result of the need to be seen to have achieved the project’s goal and more widely to be ‘good’ at collaboration, in which trust was emphasised as a crucial part of project planning. This pressure was felt by both the NHS and voluntary sector partners in the project and arguably led to a widely held “conspiracy of denial” (Milbourne, 2009, p.292) across all partners that resulted in the concealment of failures in order to emphasise success. This can potentially be explained by the emergence of collaboration as a competitive area (O’Leary and Bingham, 2009) in that failure to succeed could potentially lead to large negative implications, particularly in relation to funding. This control of the story of WE by the NHS is also an example of wider attempts to command the discourse of the project – also seen in control of the newsletter, meeting agendas and events etc. – Milbourne and Cushman (2013) suggest this is an example of the power public sector partners have over their voluntary sector colleagues, masquerading as trust.
The question that arises as a result of my research is why the NHS convened the project in a top-down fashion in light of the increased emphasis on collaboration, co-production and bottom-up ways of working seen in policy, planning, and the espoused opinions of research participants? The answer to this question lies in the emergence of collaboration as a policy goal as discussed in relation to the goals of New Public Governance in Section 3.2.3 of Chapter 3 - Literature Review.

The NHS has to been seen to be ‘doing’ collaboration in a practical sense and so they face pressure to convene collaborative projects, like Wellbeing Erewash. In addition, as funding for WE came from NHS England and was specifically required to be spent on staffing structures to enable collaborative working within the project (as described in Section 2.7 of Chapter 2 – Context), there was very little opportunity for the voluntary sector to step into the initial planning. The stipulated use of the funding, within a context of stretched budgets generally, also created a context in which the NHS locally could not themselves fund additional capacity to work in ways consistent with collaboration as conceptualized in New Public Governance. Specifically, this includes the notion of community involvement, and particularly, ‘co-production’ (Voorberg et al., 2015; Howlett et al., 2017). The ongoing position of the NHS (and other public sector organisations) as both the convener and funder of collaborative projects with the voluntary sector is therefore one of the fundamental reasons that the promise of more egalitarian relationships between the sectors has proved ‘elusive’ (Milbourne, 2013).

The lack of capacity within public sector organisations to work in a collaborative way extends to their lack of ability to work closely with communities and hence the reason that voluntary sector organisations are emphasized in both national and local policy due to their assumed close connections with their service users. Alongside this, public sector organisations face equal pressure to involve both voluntary sector organisations and individual citizens, in line with the twin emphases of co-production identified in Chapter 3 - Literature Review as a legacy of NPM and NPG practices (Osborne and McLaughlin, 2004; Brandsen and Pestoff, 2006; Howlett et al., 2017). Voluntary sector organisations themselves are in turn happy to accept this role within collaborative projects because it both conforms with some of the ‘myths’ of the sector that they
Chapter 7 Discussion

are keen to embrace – their link with communities - and promotes that myth for their strategic advantage (Alcock and Kendall, 2010; Billis, 2010). To this extent, the voluntary sector were complicit in the unrealistic representation of the Wellbeing Erewash project. This conforms with the voluntary sector literature that has suggested the sector has been complicit in accepting the wider negative aspects of collaboration with the public sector (Milbourne and Cushman, 2015; Murray and Milbourne, 2017).

Through accepting this role, the voluntary sector are subject to additional, problematic tensions. These tensions relate to the conflict between the sector acting as a ‘voice for’ communities and as a ‘route in’ to them, a twin role that Albareda (2018) has termed acting as a ‘transmission belt’. In WE this role was primarily carried out by Erewash Voluntary Action.

7.2.2 A Route in Versus Acting as a Voice – Erewash Voluntary Action as a Transmission Belt Organisation

Although much of the previous research that has focussed on the voluntary sector’s role in relation to public sector service delivery has emphasised the negative, subordinate position held by voluntary sector organisations, insights from the collaboration literature suggests a more positive position may be possible because of the interdependencies required to ‘make things happen’ (Huxham and Vangen, 1996; 2005). This is primarily in relation to the idea that public sector organisations must need something from their voluntary sector partners otherwise working together makes very little sense. Huxham and Vangen (1996) suggest that the voluntary sector has a ‘commitment to democracy’ that distinguishes them from the public and private sectors. As the NHS has a widely acknowledged ‘democratic deficit’ (Cornforth, 2003; Ruane, 2014; Benbow, 2018; Albareda, 2018) it is therefore logical to suggest that the NHS attempts to leverage this notion of democracy within the voluntary sector and the sector’s role as a ‘mediating institution’ between government and communities (Lipsky and Smith, 1995). This drive may be the fundamental reason collaboration takes place at all, particularly within a policy environment in which collaboration itself is emphasised as a policy goal (Sullivan et al., 2012).
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However, King and Griffin (2019) suggest the idea that voluntary sector organisations are ‘schools of democracy’ is flawed and it may be representative of one of the enduring ‘myths’ of the sector. In addition, there is very little research that investigates how this assumed role plays out in practice. Chapter 6 - Findings described the variety of ways Erewash Voluntary Action (EVA) contributed to the Wellbeing Erewash (WE) project. In relation to the notion of democracy, they were engaged in the project to both act as a ‘route into’ communities and a ‘voice for’ them. In practical terms this meant hosting meetings and events designed to engage with individuals from the community directly and working in an ongoing sense to represent the community themselves through their contact with the wider voluntary sector. Within this was the assumption that those wider voluntary sector organisations were themselves willing and able to represent the wider community. At times, these twin demands caused tension as described in Section 6.6, notably in relation to the legitimacy of representation between EVA and the individual community representative. Albareda’s (2018) work on ‘transmission belt’ organisations provides some insight into the impact on organisations that may be working in a way that both looks to boost ‘diverse participation’ and produce a ‘consistent message’, and they identify that this role can cause tensions, particularly around organisational capacity. However, their research has several limitations in its ability to provide insights into practice. Firstly, the data used is quantitative, gathered from an EU-wide survey of ‘senior leaders’ of voluntary sector organisations. This restricts the research findings to broad generalisations about potential roles, without any real insight into practice. In addition, as suggested previously (see Argyris and Schön, 1974), reliance on what participants say they do (their ‘espoused theories’) is often incompatible with what they actually do (their ‘theories-in-use’). Secondly, Albareda focussed on the policy influence that the organisations within the survey had, whereas my research looks at the role of the sector in service delivery. Finally, Albareda’s work does not approach the connections described between policymakers and the voluntary sector as a collaboration, as a result, the potential tensions that they describe are not contextualised within the understanding that working collaboratively is difficult and unlikely to succeed.
Despite these restrictions, the findings articulated above in relation to the twin demands placed on EVA to work as both a ‘route into’ communities and a ‘voice for’ them fit within Albareda’s conceptualisation of the voluntary sector as ‘transmission belt’ organisations – see Table 7-1 below (p.235).

Table 7-1 - Transmission Belts in Policy and Practice

<table>
<thead>
<tr>
<th>Albareda (2018) – twin demands placed on ‘transmission belt’ organisations in policy</th>
<th>This Research – how organisations enact this in practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boosting Diverse Participation</td>
<td>Acting as a ‘Route In’ to communities</td>
</tr>
<tr>
<td>Producing a Consistent Message</td>
<td>Acting as a ‘Voice For’ communities</td>
</tr>
</tbody>
</table>

(Source: Created by author and informed by Albareda, 2018)

I extend Albareda’s notion of ‘diverse participation’ to suggest that, within the practice of cross-sector collaborations, this is enacted through the voluntary sector as a ‘route into’ communities; I also suggest that the demand to produce a ‘consistent message’ is enacted through the sector as a ‘voice for’ communities. Figure 7.1 on p.236 shows how these twin demands are enacted within cross-sector collaborations.
Figure 7.1 - Role of Transmission Belt in Cross-Sector Collaboration

Importantly, the role of the NHS as conveners of the project, and the powerful position that results from this allows for this role to be dictated by the policy ambitions that led to the creation of the project in the first instance. The difficulties experienced by EVA in attempting to meet these twin demands conforms with Albareda’s suggestion that the transmission belt role is unlikely to be achievable for most organisations but again extends this to local service delivery contexts. This tension is similar to that between unity and diversity of the sector experienced by voluntary sector infrastructure organisations as described in Section 3.2.6 of Chapter 3 - Literature Review. That in turn links to the concept of a ‘strategic unity’ of the sector as described by Alcock (2010; Alcock and Kendall, 2010; Macmillan, 2013), and Albareda’s work certainly seems influenced by this conceptualisation. However, the findings of this research demonstrate how EVA experienced an additional tension through acting as a transmission belt.
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7.2.3 Killing the ‘Golden Goose’

Previous research has suggested that closer relationships with public sector organisations risk damaging the voluntary sector’s ‘comparative advantage’ (Billis and Glennerster, 1998), specifically in relation to stakeholder ambiguity – smaller gaps between those using the service and those with authority over it. Carmel and Harlock (2008) suggest that through working in partnership, the public sector is able to extend its governance of the voluntary sector, and various authors have pointed to the instrumental use of the sector when working in partnership with the state (Macmillan, 2010, Milbourne, 2013, Rees and Mullins, 2016). Voluntary sector organisations risk losing their advantage by becoming more public sector-like through the effects of ‘institutional isomorphism’ and ‘mission drift’ - chasing available money instead of focusing on their values and ‘reason for being’ (Macmillan, 2010; Milbourne, 2013; Hemmings, 2017; Egdell and Dutton, 2017), and through a widening of the gap between service users, those delivering services, and those responsible for organisational governance (Billis and Glennerster, 1998).

However, despite the overall acceptance of these issues within the voluntary sector literature, very little is known empirically about how this process takes place in practice.

The design of my research enabled a far greater range of data to be collected and analysed than in previous studies, for example, Hemmings’ (2017) data is limited to survey responses from individuals in leadership positions in the sector and lacks a focus on change over time. Milbourne (2013) emphasises the value of in-depth qualitative studies of the sector but they do not include any clear ontological or epistemological basis for carrying such a study out and, despite including observational field notes, do not consider impact in practice or data gathered through researcher participation.

Through focusing on a broad range of data gathered from the practice context, my research identified three specific points of tension in relation to the voluntary sector’s ability to carry out the transmission belt role – see Figure 7.2 on p.238. The notion of ‘tension’ in this context relates to the common usage of the term – to mean stress and/or conflict as a practical outcome – but, as this exists in a collaborative context, this tension also relates to the different choices that practitioners make between alternative forms of practice (Huxham and Beech, 2003).
Firstly, engaging directly with individuals (the community representative) after their involvement was enabled via EVA acting as a ‘route into’ the community caused tension and at times direct conflict, as described in Section 6.6.2. This risks damaging the relationship between the organisation and those individuals, who may also be the organisation’s service users. This conflict is different to the potential tensions inherent in the voluntary sector’s collaborative advantage as described by Billis and Glennerster (1998) as it is external in focus and competitive in nature – within a collaborative context - as opposed to being internally focussed on the governance of a specific organisation. This relates back to tensions in the choices made by those in control of the project – the NHS – in that they are able to decide whether to engage with and give primacy to individual community representatives or voluntary sector organisations. In WE there was often an assumption that the two would be compatible, which proved at times to not be the case.

Secondly, as described in Section 6.2.4, EVA hosted meetings and events designed to engage with...
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the voluntary sector, with the assumption that those organisations would be representative of communities. However, the lack of public sector engagement with these structures and preference for EVA to act as a ‘voice for’ the sector, meant that it was not clear if the views and opinions of the wider sector were taken account of. Thirdly, it was not clear whether the voices that were heard from the wider sector in meetings such as the Voluntary Sector Forum were purely the personal opinion of practitioners or based on engagement with individual service users and/or the wider community. This may be reflective of King and Griffin’s (2019) suggestion that the voluntary sector is merely a ‘pool’ for democracy where a limited range of people are able to ‘have their say’ and others are excluded. The assumption that voluntary sector organisations were automatically able to represent their service users relates back to wider notions about the existence of a ‘distinct’ voluntary sector and the strategic advantage this can bring (Alcock, 2010; Macmillan, 2013).

Placing EVA as the transmission belt organisation in a position that can cause conflict with both other voluntary sector organisations and their service users, as did happen in the Wellbeing Erewash project, risks damaging the comparative advantage of the sector. As the transmission belt role is one that is demanded of the sector when working with public sector organisations, the suggestion that closer voluntary-public sector working risks ‘killing the golden goose’ of the sector’s link with communities is bolstered. This is not necessarily a deliberate act by individuals but rather the result of the position the voluntary sector finds itself in when collaborating with the public sector. The NHS role as both convener and funder of collaborative projects makes this situation more likely because of the power that results in it. Despite this individuals do have some say within this process and at times within this research did acknowledge the problematic aspects of the voluntary sector’s role, their ability to change it was limited because of the traditions of power inherent in public sector practices – as will be explored in the next section.

Rees and Mullins (2016) suggest that the ‘strategic unity’ of the voluntary sector that existed during the New Labour period (1997-2008) has now dissolved because of the rise of competitive practices within the sector and between organisations. The findings of my research suggest that this competition also extends to organisational relationships with clients/service users. Insights
from the collaboration literature point to the unity/diversity tension that exists in attempting to work with multiple stakeholders in an environment that invites conflict (Saz-Carranza and Ospina, 2011; Vangen and Huxham, 2012). When combined with the fundamental tension between unity and diversity experienced by EVA as an infrastructure organisation, and the tension of acting as a ‘transmission belt’, voluntary sector organisations are exposed to very difficult circumstances in practice. In this sense, an increased emphasis on collaboration in public service delivery serves to increase the tensions of unity/diversity already experienced by the voluntary sector.

7.2.4 Summary of the Role of the Voluntary Sector in Wellbeing Erewash

The findings of my research described how at times the voluntary sector was acting as both a ‘route into’ communities and a ‘voice for’ them. This twin role created tensions both between organisations and in organisational relationships with service users. This was primarily related to the role the NHS had in convening the Wellbeing Erewash collaboration and therefore their ability to set the terms for how the project would work. This emphasis on working with the voluntary sector reflects assumptions about the inherent benefits the sector enjoys over others – its comparative advantage – but in attempting to leverage this in a way that uses the sector instrumentally within the drive to implement collaboration as a policy goal, rather than as a fundamental process, the public sector risks damaging the very thing it seeks to benefit from (Billis and Glennerster, 1998).

As much as there were tensions and conflict within the voluntary sector’s role in Wellbeing Erewash, the findings of my research hint at the sector’s ability to deal with this conflict in a constructive manner as the Community Representative continued to be involved with EVA even after they had withdrawn from the project. Flyvbjerg (1998b) suggests the voluntary sector is necessary for productive conflict in society and much of the literature in relation to collaborations suggests that conflict is a crucial part of both success and failure (Gray, 1989; Cropper, 1996; Huxham and Vangen, 2004; Provan and Kenis, 2008; Vangen and Huxham, 2012). Therefore, having an organisation – and potentially a whole sector – that is able to absorb such conflict and work towards a productive use of the energy that it brings would seem to be vital to the success
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of collaborative ways of working. The flexibility that is needed to enable this role is perhaps more likely in organisations without strong hierarchies, processes, and structures that regulate practice – what Bachmann (2001) would term as lower system power. Of course, an alternative explanation exists for these particular findings in that it may purely have been the personal relationships involved between participants that influenced how they worked together. Certainly, personal relationships appear to be important for collaborations between the voluntary and public sectors (Macmillan, 2010; Cairns and Harris, 2011; Milbourne and Cushman, 2013). However, even if in this instance personal relationships were the reason for these findings the case can still be made that the voluntary sector is more likely to provide an environment in which personal relationships can flourish because of the existence of higher levels of personal trust and power. The suggestion from this research therefore is that the uniqueness of the sector is (in part) the ability to deal with contradictory elements and conflict within a tradition of personal power and trust, as the next section will explore. As referenced above, the dominance of the NHS within the Wellbeing Erewash project meant that they maintained a high level of control over certain aspects of it. Control itself is has been suggested as a function of both power and trust (Ran and Qi, 2018), and all three are said to interact within collaborative contexts (Bachmann, 2001).

7.3 Trust, Power and Control in Wellbeing Erewash

Table 7-2 (p.242) provides a reminder of the definitions of trust, power, and control used in this thesis. It is a reproduction of the relevant sections of Table 1-1 (p. xiii).
**7.3.1 Control over Resources, Information, and Narrative**

Section 6.6 of Chapter 6 - Findings details the aspects of control within the Wellbeing Erewash (WE) project. These findings show how the notion of ‘control’ dominated the data but often referred to different aspects. Four overlapping areas of control were identified, top-down; bottom-up; middle-down; and middle-up. The ‘top’ of control was primarily inhabited by national NHS bodies and local clinical/professional influences. The notion of the ‘bottom’ relates to ideas of community and co-production inherent in the policy influencing WE. This is inclusive of the twin conceptualisations of co-production and the assumption that the voice of the community can be accessed either by engaging individual citizens or by working with voluntary sector organisations (Brandsen and Pestoff, 2006). The sector’s position as ‘the bottom’ in any engagement within the project was often determined by the presence or absence of community representatives and/or the capacity of the NHS to directly engage with individuals. As a result of this, and of the role of the NHS in controlling how the sector was involved in the project, the voluntary sector was often in ‘the middle’, working both upwards to the NHS and downwards towards the communities they represent. However, as noted in Section 3.2.3 of the Literature Review, co-production under the ideals of New Public Governance emphasises the role of the

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**Table 7.2 - Definitions of Trust, Power, and Control**

<table>
<thead>
<tr>
<th>Trust</th>
<th>In its broadest sense trust is a means of coping with uncertainty and “works on the basis of positive assumptions about alter ego's willingness and ability to co-operate” (Bachmann, 2001, p.350). It is the ‘entangled twin’ (Ran and Qi, 2018) of power. Like power, traditions of trust exist at the personal and system level.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Power</td>
<td>In collaborative contexts power is a mechanism, entangled with trust (Ran and Qi, 2018), that acts upon the function of control “based on the selection of a negative hypothetical possibility regarding alter ego's (re-)actions” (Bachman, 2001, p.350). Traditions of power exist at both the personal and system level.</td>
</tr>
<tr>
<td>Control</td>
<td>Control in this thesis refers to the direct ability to make decisions about aspects of voluntary-public sector working. It is what Bachman (2001) suggests is about the coordination between organisations. In this sense control is a ‘function’ shared by trust and power (Ran and Qi, 2018).</td>
</tr>
</tbody>
</table>

(Source: Created by author and extracted from Table 1-1, p.xiii)
individual as the unit closest to communities (Brinkerhoff, 2002). Several interviewees expressed a preference for engagement directly with individuals, and in practice the viewpoint of the single Community Representative was treated as the voice of the community as a whole, as noted in Section 6.6.2.1. The sector also had very little influence on when or how they were engaged with by the wider project in terms of representing the community. These restrictions, coupled with a lack of control over the financial aspects of the project, meant that the voluntary sector had little overall control of the WE project itself.

These findings are not unusual and previous research has pointed to the influence exerted over the voluntary sector by the state, particularly in relation to funding relationships (Milbourne, 2009; Hardill and Dwyer, 2011; Rees et al., 2016; Egdell and Dutton, 2017). Certainly, the position of the NHS as funder of Wellbeing Erewash gave them a strong position and further to this, as explored in the previous section, the role of the NHS as the convener of the project meant that their control of the project was established from the start.

However, as some of the previous literature has suggested (6 and Leat, 1997; Rees et al., 2012) the sector did not totally lack agency in relation to this aspect of its role. Voluntary sector organisations – EVA in particular – made a choice to get involved with, and then continue to be involved in, the project. This involvement in a project that they seemingly had little control over could have represented a real risk to EVA; Vangen and Huxham (2003a) suggest that the very existence of voluntary sector organisations can be endangered by their involvement in collaborative working, because they risk giving up control of their organisational remit to the collaboration itself. However, for EVA, although they seemed to lack control over the project, their role in it gave them the advantage of control in relation to the voluntary sector as a whole, through their position as the main contact and route through which information about the project flowed in and out of the sector. In a practical sense then, ‘giving up’ control within the project in exchange for bolstering the organisation’s position outside of it was perhaps a price worth paying for EVA. This highlights that collaborative projects do not exist in isolation from other aspects of working life for organisations (Huxham and Vangen, 2004).
This research therefore contributes to the literature around control in voluntary-public sector collaboration by suggesting that in supporting this aspect of the project – giving up control over how it was organised and implemented – the voluntary sector risk giving up their position in relation to representing their service users and wider communities. Within an austerity context, this also risks the possibility of the sector expressing a critical voice in its relationship with the public sector (Hemmings, 2017) and risks damaging the sector’s comparative advantage as explored in the previous section of this chapter. In addition to this, as control of narrative is also a key aspect of overall control (Ran and Qi, 2018), the lack of emphasis on the voluntary sector in the ‘story’ of Wellbeing Erewash reflects the difficulty the sector has in establishing their importance in a longer-term sense. The voluntary sector therefore ‘gave up’ or rather, accepted not being able to establish, control through their involvement to a far greater extent than the NHS. This inability to ‘give up’ control from an NHS perspective reflects the reduction in professional autonomy suggested in the literature around New Public Management (Bezes et al., 2010; Lundström, 2015), and the reduction in personal power that emerges as a result (Bachman, 2001). In contrast, system power – power inherent in the systems and processes – serves to restrict the ability of individuals to truly give up power - and therefore the control of – collaborations (Bachmann, 2001; Ran and Qi, 2018). Despite a lack of control over the project as a whole, the voluntary sector – through EVA – did have control over certain aspects – as described in Section 6.2 – as such, notions of control are not absolute but related to interactions of power – which is in turn related to trust – within collaborative environments.

### 7.3.2 Interactions of Trust, Power, and Control in Wellbeing Erewash

As Bachmann (2001) and Ran and Qi (2018) suggest, control is a ‘function’ that is shared by trust and power. Power and trust are “entangled twins” (Ran and Qi, p. 624) and so cannot be considered in isolation of each other. As such, the findings of this research that refer to the daily process of making decisions in relation to the Wellbeing Erewash (WE) project are manifestations of trust and power in practice. This is important in two specific ways. Firstly, it is important to
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acknowledge the different ways in which power is dealt with in practice – participants rarely mentioned power in either interviews or in their actions, but control was emphasised greatly, particularly in relation to working from the ‘bottom-up’. Secondly, although the notion of trust was found far more frequently in the data than power, it was treated by participants as an independent aspect of practice, rather than as related to other concepts – such as power – or other aspects of the practice of the project, such as control of decision making. The fact that trust was singled out for so much attention in both policy and practice suggests that rather than considering it as a ‘fuzzy logic’ (Bachmann, 2001) or as a complex process that requires nurturing over time, as much of the literature would suggest (Vangen and Huxham, 2003a; Kramer et al., 2018), it has been treated as a ‘normative policy good’ (Osborne et al., 2016) in itself, i.e. that trust is a goal to be achieved and once it has been achieved it can be claimed indefinitely. This is despite evidence that collaborations can be successful even when trust is absent (Getha-Taylor et al., 2018). Section 6.4.4 of the findings details how in Wellbeing Erewash trust was treated as a policy goal, and both an enabler and an outcome of the project.

In contrast, the emphasis on control in policy and practice implicitly acknowledges the importance of both trust and power as they are unavoidably linked. Therefore, without an explicit consideration of how trust, power, and control interact it will be very difficult for practitioners to navigate the complexities of collaborative working. For the voluntary sector in particular, this is highly important as their involvement in Wellbeing Erewash was from a position of ostensibly less power than the NHS, due to the latter’s position in convening and funding the project – a position typical in voluntary-public sector working (Huxham and Vangen, 1996; Milbourne and Cushman, 2015). This played out in practice in the ways the sector was missing from crucial aspects of the project, such as the ‘Leadership Team’ meetings as Section 6.2 of the findings described.

Although some of the previous empirical research identified in Chapter 3 - Literature Review - does consider the interactions of trust and power in collaborative settings (Huxham and Vangen, 1996; Vangen and Huxham, 2003b; Milbourne and Murray, 2017a), it does not focus on the ways that these two elements influence control, as suggested in the theoretical work of Bachmann.
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(2001) and Ran and Qi (2018) – Table 7-3 below (p.246) details the different traditions of trust and power.

**Table 7-3 - Personal and System Trust-Power Traditions**

<table>
<thead>
<tr>
<th>Tradition</th>
<th>Personal</th>
<th>System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust</td>
<td>Inherent in personal interactions - That other individuals will act in the way that is expected/promised</td>
<td>Inherent in structures and rules – trust is in following these. Individuals are ‘access points’ to these rules</td>
</tr>
<tr>
<td>Power</td>
<td>That individuals have the ability to do the things they promise</td>
<td>Power is part of system structures and rules – individuals don’t have the power to alter these</td>
</tr>
</tbody>
</table>

(Source: adapted from Bachman, 2001)

Bachman does not provide a clear explanation of ‘control’ in his work and similarly Ran and Qi (2018) are somewhat vague about the separation between control and power. Bachman’s (2001) emphasis on trust and power “[producing] very different qualities of relationships” (p.351) implies control is the outcome of trust and/or power i.e. they way that trust and/or power are enacted.

It’s also important here to emphasise that Bachman is speaking of control within collaborative contexts specifically, rather than as a broader concept. In contrast, trust and power in Bachman’s work are dealt with as concepts. Control can therefore be viewed as the implementation of traditions of power and trust within collaborative contexts.

My research does support to some extent Lotia’s (2004) explanation of the sources of power within collaborative settings, including identifying the ‘resource power’ of the NHS as funder and convener and the ‘connections power’ of the voluntary sector in linking with other organisations and individuals. In addition, Milbourne and Cushman’s (2013) overview of trust between the voluntary and public sectors – described in Section 3.3.1 of Chapter 3 – Literature Review - offers some insight into the breakdown of trust seen towards the end of the WE project. This includes that the ‘personal’ aspects were undermined because of a lack of confidence the NHS would act in the way they had promised; in terms of ‘competence’ in the sense that there was a decreasing confidence that NHS partners could or would do what they said in the face of restrictions; and ‘motivational’ aspects in that the voluntary sector were marginalised when reporting the impact of the project and when discussing sustainability. Furthermore, Vangen and Huxham’s (2003a)
notion of the need to ‘nurture’ trust in collaborations would suggest that the breakdown of trust in WE was as a result of a lack of active management and trust-building loops within the project itself. However, the lack of a consideration of the potential for different ‘traditions’ of trust and power mean that any nurturing is likely to be difficult because interactions between sectors will be based on these different traditions. Milbourne and Cushman (2013) do consider the interactions of trust and power in drawing on the notion of ‘masquerade’ (trust masquerading as power) but their focus on a critical examination of public-voluntary sector relationships results in an emphasis on voluntary sector disillusionment and exclusion from public sector policy and delivery and the effect this has on trust, rather than on the interactions between the two in a cross-sectoral context. In addition, they approach power as implicitly bad and trust as implicitly good whereas both have potential advantages and disadvantages in collaborative contexts (Bachman, 2001). Other research suggests the interactions between the two are not as straightforward, and trust can overcome imbalances in power (Vangen and Huxham, 2003a). However, Milbourne and Cushman (2013) draw on theoretical insights from Bachmann (2001) that are useful in explaining the differences between the voluntary and public sectors, in relation to the sectoral traditions within them. Table 7-4 on p. 248 sets out some of these differences as found in Wellbeing Erewash.
Sections 6.4.1 and 6.5.2 of the findings highlight the traditions of trust and power as manifest in practice in personal interactions; Sections 6.5.1 and 6.6 demonstrate the search for ‘balance’ in power and control that highlights how both were interrelated in practice. Bachmann’s (2001) work provides a lens from which to view these interactions and the frustrations created by the clash of traditions between the voluntary and public sectors in collaborative settings. For the voluntary sector, their interactions on a personal level with NHS colleagues represent interactions of personal power and there was an expectation that both parties would be able to act in the same way within their organisations to effect the change that was discussed, however, for the NHS employees involved in the project, such personal interactions were merely ‘access points’ into the system trust within the NHS organisation and representative of the hierarchies, structures, rules, technical guidance etc. that saw the NHS dominate the control of the project. As a result, although both voluntary sector and NHS workers saw representatives of the voluntary
sector as vital to the project, the NHS tradition is to view these interactions with individuals in meetings, events etc. as representative of the system trust assumed to exist in the voluntary sector as a whole. That system trust does not in fact exist because of the diversity of the voluntary sector, and the inability of individual representatives to act as a voice for the sector as a whole. This results in a situation in which even when a shared dialogue and experience between the sectors is developed there will be very different assumptions – based on sectoral traditions of trust and power - regarding practical outcomes of interactions. For example, we see within the findings that Erewash Voluntary Action were used as the representatives of the voluntary sector and (at times) as the voice for communities. This is unproblematic from a system power perspective as the individuals involved would be seen to act consistently with their organisations and their organisations to act consistently with their sector. Equally, the recruitment of only one ‘community representative’ is consistent with this approach as they would be assumed to be giving opinions consistent with the rest of the community. Furthermore, the attempts by NHS staff to control voluntary sector workers highlighted in Section 6.6.1.3 can be explained as an assumption that NHS hierarchy (and therefore system power) extended to those voluntary sector workers within the project – under the same ‘badge’. The objection to this by the voluntary sector shows how this was seen as an abuse of power by the individual in question – personal power being the tradition of the voluntary sector. Failures to ‘give up’ or ‘share’ control and/or power therefore continue because on the NHS side, individuals do not have the personal power to make this happen in practice. From the voluntary sector side, individuals and organisations have far more ability and autonomy to give up or share their power, because for the most part their sectoral power is personal. Previous research (Jacklin-Jarvis, 2014; 2015) has described how the tensions inherent in collaborations are experienced differently by public sector and voluntary sector participants, this too may be a result of the different traditions of trust and power in the two sectors.

Bachman’s (2001) approach to trust and power traditions acknowledges the different macro and micro elements suggested by Huxham and Beech (2008) but suggests that these are not separate but interacting elements. This is closely related to – as acknowledged by Bachman (2001) –
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Giddens’ notion of ‘structuration’ and the interaction of structure and agency. Huxham and Beech’s (2008) notions of micro and macro power are both therefore influenced by personal and system traditions. This allows us to consider not just the organisations involved in collaborative working but the wider influences upon those organisations. Therefore, Lister’s (2000) assertion that ‘micro’ aspects of power are more important than ‘macro’ aspects also ignores the fact that these are indelibly linked. Kähkönen (2014) notes that collaborations work best when there are no major disparities of power between organisations, the insights above suggest there is a need to consider disparities not just in terms of relative levels of power but also in relation to different traditions.

7.3.3 Summary of Trust, Power, and Control in Wellbeing Erewash

Trust, power, and control were important aspects within Wellbeing Erewash. Crucially, it was the interactions between these three aspects that influenced how the project worked in practice.

Notions of control dominated the data and references to power were limited. However, the two concepts – in addition to trust – overlap in a way that means they should be considered together in collaborative contexts.

Much of the control of the project was held by the NHS, which is to be expected based on their role as convener and funder. However, this control extended not just to the structures of the project but to the narrative and story told about it, and the way information flowed within it.

Much of this was to the exclusion of the voluntary sector, even when – such as with the Voluntary Sector Forum – they were leading on attempts to share information. However, the voluntary sector was able to enact some control within the project. Erewash Voluntary Action (EVA) benefitted from their position as the ‘middle’ aspect of the project to control information flows upwards to the NHS and downwards to the rest of the voluntary sector. This position bolstered EVA’s profile within the sector and with NHS colleagues, however their ability to truly influence the project was limited.

Bachmann (2001) offers us a way to consider the interactions of trust, power, and control by focussing on different traditions of system/personal trust and power. Applied to the voluntary
sector and NHS in Wellbeing Erewash we can see aspects of distinct traditions that prevent successful collaborative working in practice and lead to frustrations that emerge when the promises of policy are not successfully implemented. We can speculate that the diversity we see in the voluntary sector is likely to work against the institutionalisation of trust and power. This increases the likelihood of personal power dominating, which we see in notions of flexibility, innovation, autonomy etc. Personal power traditions may also enable the ‘comparative advantage’ of the sector, as identified by Billis and Glennerster (1998). However, it may also be the case that the comparative advantage of the sector enables personal power traditions to thrive. In contrast, the public sector – and the NHS in particular – is dominated by hierarchy, bureaucracy, shared norms, and rules, which suggest a high level of system trust and therefore system power. This is not to say one is better than the other but that the traditions in both are different. These differences, and the lack of shared norms as a result, suggest personal power and personal trust will dominate in environments where the two sectors come together, not as any ‘fault’ of either but as a result of the differences between them. We can see this in the importance attached to personal relationships in collaborations (Huxham and Vangen, 2004; Getha-Taylor et al., 2018). Interactions between the two sectors – one which relies on high personal power and one which relies on high system power – will therefore be difficult. The implication here is that voluntary sector and NHS participants in collaborations will require different approaches to getting the most out of their working relationships because of their different starting points. Like Bachmann, I am not attempting to say one side is ‘better’ than the other but suggesting that these differences and complexities of trust and power traditions are part of what makes collaborative projects difficult.

My research contributes to this work by offering empirical evidence for Bachmann’s theory, and by applying his notion of national traditions to sectors within a UK context. In addition, I have described how notions of trust and power in collaborative contexts present in previous literature are restricted in relation to their treatment of the interaction between micro and macro levels of trust, interactions between them, and in relation to the importance of sectoral traditions in cross-sector collaborations.
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The research did uncover some aspects of a developing system trust within the project – the ‘assumed trust’ noted by one participant, and the developing structures of engagement with the voluntary sector – however, as the project neared its end these structures were largely abandoned. More importantly for the voluntary sector, those personal relationships – that from a sector point of view were representative of personal power – also dissolved as individuals moved on to other projects. This is not uncommon in collaborative contexts (Huxham and Vangen, 2000b)

7.4 Leadership in Wellbeing Erewash

Leadership in the Wellbeing Erewash project was a complex mix of various aspects that have different traditions in the academic literature. Section 6.8 of Chapter 6 – Findings, detailed the strong influence of NHS hierarchies, particularly in relation to clinical expertise; the focus on individual influence and personal skill development needed to operate within and influence these hierarchies; aspects of relational and shared leadership, particularly between voluntary and public sector employees; and a focus on ‘getting things done’ which reflects notions of ‘making things happen’ (Huxham and Vangen, 2000a) in order to drive the project forwards. The findings of my research therefore reflect much of the previous literature in relation to the complexity of leadership within the voluntary sector, the NHS, and in relation to organisational collaboration (Huxham and Vangen, 2005; Currie et al., 2009; Hodges and Howieson, 2017; Jacklin-Jarvis et al., 2018). The contribution of this thesis is to draw attention to this complexity in relation to NHS voluntary sector collaboration and in particular the ongoing influence in practice of hierarchies and clinical aspects of the NHS. In addition, it suggests attempts to address this through more ‘collaborative’ approaches can act to reinforce these hierarchies. The research also positions voluntary sector involvement in the face of such restrictions as a pragmatic leadership response particularly in relation to the increased emphasis on collaboration as a policy goal, influenced by the legacies of New Public Management and New Public Governance. In addition, despite these restrictions the voluntary sector – Erewash Voluntary Action – were able to enact a leadership approach that helped to ‘make things happen’ in a practical sense.
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7.4.1 Leadership Hierarchies

Building on the findings of this research that suggest the NHS maintained a large amount of control because of their position as funders and conveners of the project, and the discussion in Section 7.3.2 that suggested the NHS is likely to be dominated by system power and trust, it makes logical sense to have found the presence of strong leadership hierarchies within Wellbeing Erewash, as Section 6.8.2 details. These hierarchies represent the structures and rules we would expect within a system trust and power environment (Bachmann, 2001). In addition, the dominance of clinical professionals fulfils the expectation of technical and procedural aspects of system power – this is at least partly the case because of the embedded dominance of the ‘medical model’ (as opposed to the social) within the NHS as we shall see below.

Much of this leadership dominance by the NHS is predicted by the collaboration literature in the importance placed on the role of convener and funder (Gray, 1989) and supported by the voluntary sector literature which emphasises the sector’s position as the ‘junior partner’ or as ‘subordinate’ to the public sector in collaborative or partnership working (O’Brien, 2006; Milbourne, 2009). However, much like the difference between personal/system power/trust is not a normative judgement, the dominance of hierarchy was not necessarily a negative for the possibility of the voluntary sector enacting leadership within Wellbeing Erewash. In particular, this worked to the advantage of the organisation named within that hierarchy as the ‘lead’ for the voluntary sector – Erewash Voluntary Action (EVA). EVA were able to enact their hierarchical leadership position through their access to meetings and events. However, this was most often through the Chief Executive as an individual and the expectation that they would act as the voice for the organisation, the sector, and at times even the whole community of Erewash. This links back to the assumption within high ‘system power’ environments that individuals act as ‘access points’ to such a consistent structure and way of working. Nevertheless, this highlights the importance of individual leadership within the project, as either representative of wider structural aspects of power (from the NHS perspective) or personal aspects (from the VS and community engagement perspective). This is in keeping with traditional ‘heroic’ approaches to leadership that
emphasise the role of the individual (Grint, 1997; 2010b; Jackson and Parry, 2011; Alvesson and Spicer, 2014).

A further issue with the role of hierarchy in the project is that leadership ‘of’ the voluntary sector amounted to whichever person or organisation happened to be ‘in the room’ or named officially in that hierarchy. Although both voluntary sector and NHS participants noted on several occasions that no single person or organisation could fully represent the sector this was nevertheless how the process worked in practice. This creates issues for leadership in relation to the legitimacy of any organisation or individual to speak on behalf of the whole of the sector. Although Macmillan and McLaren (2012) have suggested competition has created a situation in which there is less of a ‘sector’ identity, my findings suggest that the emphasis on engaging with the sector has made it more likely individual organisations will accept a role as ‘representing the sector’ in practice. This is in part because of the fear – in a competitive environment – that if they do not do it, they will lose their seat around the table.

Although representation does not necessarily equal leadership in a general sense, often the ‘lead’ for the voluntary sector within the project was related to the organisation or individual seen to be representing the sector. In a hierarchical sense this was often dictated by the NHS.

The NHS itself is of course not a homogeneous organisation and there are various elements of hierarchy within it. Notably this included the dynamic between NHS England (nationally) and Erewash CCG (locally). One aspect of leadership that runs through both national and local NHS contexts is that of the priority given to the clinical professional voice. These findings are consistent with the work of Ham (2003) and Malby et al. (2013) who have suggested that leadership within the NHS is primarily the domain of clinical professionals, and Anandaciva et al. (2018) who note that leadership is still a ‘top-down’ burden within the organisation.

Despite the noticeable and commanding presence of hierarchy and authoritative leadership in Wellbeing Erewash, my research also uncovered aspects of leadership that are in contrast to those purely top-down aspects, which I will group under the general heading ‘sharing leadership’ and discuss in the next section.
7.4.2 Sharing Leadership

In addition to the strong aspects of hierarchical leadership identified in this research, the Findings chapter also detailed how attempts were made to share leadership within the project. This particularly included shared action planning between the CEO of Erewash Voluntary Action (EVA) and the NHS lead for Community and Personal resilience. It also extended to the EVA CEO being invited to take part in the EMLA Leadership Development Programme which was an explicit – albeit limited – attempt to extend the concept of leadership to the voluntary sector. The Voluntary Sector Forum, run by EVA, was another attempt to engage the sector in a leadership role, although it was not formally acknowledged as such and the engagement process of the forum was not carried out in practice (see Section 6.2.4.1). The Forum’s existence influenced leadership within the sector in that – in theory - organisations other than EVA as the ‘named lead’ were able to have their say about the Wellbeing Erewash project and influence EVA’s approach to it. However, the issue in relation to this engagement was firstly that the theory of how the Forum should work did not play out in practice, and secondly that even with a full room of participants the large majority of voluntary sector organisations in Erewash were not represented. This reflects the issue infrastructure organisations have around engagement and representation as Mohan (2012) has previously drawn attention to. The problematic element is that this representative power was often invested in single individuals – the CEO of EVA, and the community representative rather than in processes that would have widened engagement.

Vangen and Huxham (2003b) point to the important of structures, processes, and participants in leading for collaborative advantage, my research suggests that, within Wellbeing Erewash, attempts to enact collaborative leadership structures were thwarted by an incomplete process that in turn led to the role of specific participants becoming emphasised.

This to some extent supports Sutherland et al.’s (2014) suggestion that attempts to move away from formal hierarchical or authoritative aspects of leadership risk reproducing the very thing they would wish to overcome by failing to acknowledge the informal hierarchies at work. In the case of Wellbeing Erewash this includes the power and trust dynamics both within the voluntary sector and between the sector and the NHS, particularly related to the role of funder and
convener. Attempts to share leadership were therefore restricted by the wider context. This finding adds evidence to Currie et al.’s (2009) suggestion that there are competing ‘institutions’ of leadership within the UK public sector – individual leadership responsibility at the top of formal hierarchy on the one hand and shared/distributed aspects on the other. My research suggests that the former still dominates the latter in relation to how the NHS interacts with the voluntary sector. As noted previously, within the NHS itself, the attempts to ‘share’ aspects of the leadership hierarchy extended primarily to clinicians, specifically GPs. This had the impact of sharing leadership within the NHS but introducing an additional, stronger hierarchy in relation to the voluntary sector. ‘Sharing’ in this context then was about sharing within the NHS between clinical and managerial staff and attempting to move away from the clinical or top-down notion of leadership in the organisation described previously. Unfortunately, this was both largely unsuccessful internally and restricted the inclusion of the voluntary sector in this sharing.

Although the voluntary sector struggled to influence more senior or strategic levels, one aspect of the project they were able to enact leadership within was the interpersonal or relational interaction between individuals who were tasked with implementing the project in a collaborative way. These relational aspects were primarily visible in the interactions between the CEO of EVA, the NHS programme lead for Personal and Community Resilience, and the Community Representative.

7.4.3 Leadership and Personal Relationships

The key relationship within Wellbeing Erewash identified in the findings was that between the EVA CEO and the NHS Community and Personal Resilience lead worker. Section 6.8.5 details this relationship. To summarise, it included close personal support; joint responsibility for reporting on progress at meetings, and feeding back about those meetings; regular informal conversations about the project; the creation of a joint ‘action plan’; sharing responsibility to follow up aspects of the project etc. The close working relationship between the two meant that in a practical sense, much of the day-to-day work of the Community and Personal Resilience workstream was co-created. This supports aspects of relational leadership (Cunliffe and Eriksen, 2011) which
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suggest leadership is co-constructed between individuals and the spaces – physical and conceptual - they occupy. Ospina and Foldy (2010; 2015) and Crosby and Bryson (2014) have drawn attention to the importance of relational approaches in collaborative contexts, albeit with a focus on the USA and on the positives of potential approaches. For the voluntary sector this has advantages and disadvantages. In terms of the project itself it enables the sector to contribute leadership in a way that corresponds with the value placed on personal interactions in both service delivery and organisational collaboration (Windrum, 2014). In addition, EVA in particular benefitted from having a physical space in which people felt comfortable, particularly NHS employees as Section 6.6.1.3 describes. However, as discussed previously, these relationships are vulnerable to breakdown, notably if specific individuals leave their roles. This was a particular feature of the WE project in the final few months and is not uncommon in collaborative contexts (Huxham and Vangen, 2000b). Further, there is the danger of different traditions of trust and power impacting the ability of individuals from different sectors to truly share their ways of working and on the ability of those from different traditions to react to the inevitability of change in this way. Within WE, we can see this in that although there was a large amount of emphasis placed in policy on sharing leadership, control, and working with others, in practice the limited attempts to enact this were most often unsuccessful.

These personal relationships and the attempts of individuals to share leadership were in tension with the leadership hierarchies described in Section 7.4.1. Often the hierarchies of the NHS, which are representative of the organisation’s system power dominated these more personal aspects. Hierarchy also allowed the project to overcome the loss of the community representative when they chose to disengage from the project, as noted in Section 6.6.2. This leadership role had been invested in the community representative by virtue of the position they had been granted in the hierarchy of the project. Although ostensibly at ‘the bottom’, the policy emphasis on working from the ‘bottom-up’ actually placed great importance on this role. This points at the need for ‘workable blends’ of hierarchy and participatory elements in collaborations (Crosby and Bryson, 2014), however, my research questions whether this blend is actually workable in relation to the goal of sharing leadership. In particular, the role of voluntary sector organisations as ‘transmission
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belts’ creates tensions between community and organisational representatives in the sector, meaning that at times an aspect of sharing leadership – wider engagement – may trigger tensions that lead to a more authoritative or hierarchical response, in order to either prevent certain individuals having influence, or asserting organisational position and legitimacy.

The voluntary sector was able to enact leadership in order to ‘get things done’ in spite of the wider restrictions of hierarchy and personal dynamics at play. The way in which this was achieved reflects Vangen and Huxham’s (2003a) notion of ‘making things happen’ and included both facilitative aspects – working in the spirit of collaboration, and directive – in a more authoritative fashion. The next section will discuss how this was achieved.

7.4.4 Making Things Happen

Section 6.2.4 of the findings details how Erewash Voluntary Action (EVA) worked within the Wellbeing Erewash (WE) project to ‘make things happen’, including: employing the ‘community connectors’ worker; administering the forums for the project (effectively for free); sharing information and expertise to prevent duplication of work; and wider initiatives with other organisations in the sector that met the goals of the project. Section 6.2.4 goes on to detail how EVA worked in ‘manipulative’ ways in order to progress the work of the project through attempting to influence key individuals, refusing to work with some other organisations, and commissioning their own evaluation. This conforms with what Huxham and Vangen (2005) would suggest is the practice of leadership within collaborative contexts – that it is concerned with whatever contributes to the outcomes of the work itself. As a result, leadership in collaborations is a combination of acting in both facilitative (in the spirit of collaboration) and directive (more authoritarian, less collaborative) ways. This is legitimate as it is focussed on attempts to leverage the collaborative advantage of working together, however, enacting directive approaches outside of the specific collaborative environment may have a negative impact on wider organisational and personal relationships as it lacks that moral justification (Huxham, 1996)

The voluntary sector’s ability to exist in this environment and enact different leadership approaches is broadly positive, certainly EVA benefitted. However, the directive leadership
behaviours that are necessitated and justified in relation to the leadership in collaborative settings may go against wider conceptions of what is unique about leadership in the voluntary sector as a whole – its collaborative (i.e. facilitative) characteristics (Howieson and Hodges, 2014; Hodges and Howieson, 2017). This latter approach conforms to wider notion of collaboration as a style or form of leadership such as detailed by Chrislip and Larson (1994) – i.e. collaborative leadership rather than leadership in collaborations. Figure 7.3 (p.259) shows this distinction.

**Figure 7.3 - Leadership for collaboration versus collaborative leadership**

Chrislip and Larson (1994) themselves do acknowledge that at times even a collaborative style of leadership requires ‘Machiavellian’ tactics in order to succeed. Hodges and Howieson (2017) note that political austerity has forced voluntary sector organisations to work more collaboratively in order to survive. To use their terminology, the ‘triple strength’ of leadership in the sector – values, collaborative working, and survival – have become dominated by the competitive aspects of survival. What this means in practice, as my research demonstrates through focussing on the actions of EVA, is that although austerity has pushed the sector to engage more in collaborations, this does not necessarily mean the sector has become more collaborative if we take merely the positive implications of collaborative leadership as emphasised by Hodges and Howieson (2017).
and in much of the grey literature. Leadership in the voluntary sector in practice therefore is about more than just the positive aspects and may have more in common with competing institutions of leadership in other sectors and settings (Currie et al., 2009). This side with Alvesson’s (2017) point that leadership literature suffers from a disconnect from what happens in the real world.

Care should be taken in voluntary sector organisations to ensure that whichever leadership approach is enacted is justifiable in relation to both the specific context and organisational values. Collaboration itself has become a ‘normative policy good’ (Osborne and Strokosch, 2013) that organisations compete over. To be successful in this competition requires directive as well as facilitative approaches, often at the same time (Vangen and Huxham, 2003b). In this sense leadership in the sector actually mirrors leadership within collaborations and this gives rise to the possibility of viewing the sector through the lens of collaboration in a more general sense.

Voluntary sector leadership in ‘making things happen’ within a collaboration therefore would reflect wider leadership efforts to ‘make things happen’ at a societal level. Figure 7.4 below (p.260) shows this possibility.

\[\text{Figure 7.4 - Facilitative and Directive Leadership in the Voluntary Sector}\]

(Figure: created by author based on research findings and informed by Vangen and Huxham, 2003a)
The findings of this research are supported by some of the wider Leadership Studies literature which focuses on the need for ambidextrous’ (Rosing et al., 2011; Zacher et al., 2014; Pina e Cunha et al., 2015) ‘hybrid’ (Gronn, 2009; Quick 2015) and ‘complex’ (Burns, 2002; 2008; Uhl-Bien et al. 2007; Uhl-Bien and Arena, 2017) forms of leadership that incorporate different styles and forms of practice. In a specific voluntary sector context, these findings also speak to Kay’s (1996) suggestion that the interplay of unity and diversity is at the heart of leadership in the sector. This paints leadership as a paradoxical concept (Bolden, 2016) within a paradoxical phenomenon (collaboration) (Vangen, 2017) in a paradoxical (voluntary) sector (Kay, 1996). Despite policy and espoused opinions of practitioners using the language of collaboration, they do not acknowledge the ‘thuggish’ (Huxham and Vangen, 2005) or ‘disruptive’ (Jacklin-Jarvis, 2014) aspects of what this means in practice, particularly for relationships with other service users and citizens. NHS (and wider public sector) policy treats collaboration as a ‘magic bullet’ (Vurro et al., 2011) for addressing the complex problems faced by society.

7.4.5 Summary of Leadership in Wellbeing Erewash

NHS hierarchies played a large role in the leadership of the Wellbeing Erewash project. This was despite attempts in policy and practice to introduce more shared aspects of leadership. This reflects Currie et al.’s (2009) findings of different ‘institutions’ within public sector leadership in the UK. However, my research found that authoritative, hierarchical leadership continues to dominate, particularly in relation to the role of clinical professionals within the NHS. However, for Erewash Voluntary Action, as the ‘named lead’ for work with the sector, their role in this hierarchy was somewhat advantageous as it enabled them to grow their profile. Unfortunately, this profile and position was invested in them by the NHS – as was the position of the community representative as the ‘north star’ for the project – and as a result was easily removed. There were some attempts to share leadership in relation to the EMLA leadership programme and in how the EVA CEO and NHS Personal and Community Resilience Lead worked together, but this was limited. EVA were able to enact leadership by ‘making things happen’ in the project either through facilitative aspects, such as recruiting and employing the ‘community connector’ role or through
directive aspects, such as refusing to assist with the shortfalls of other organisations. These findings reflect the literature on leadership in collaborations (see Vangen and Huxham, 2003b; Huxham and Vangen, 2005) but to some extent stand against the literature on leadership in the voluntary sector that either explicitly or implicitly suggests a key aspect is some form of ‘collaborative’ leadership (Howieson and Hodges, 2014) that is only related to ‘positive’ aspects: empowering people, ensuring quality, championing innovation etc.

With the current emphasis on collaboration as a ‘normative policy goal’ (Osborne and Strokosch, 2013) in NHS policy, and the subsequent pressure to engage with the NHS on the terms that the voluntary sector has felt in austerity (Milbourne and Cushman, 2017), combined with the emphasis on working in non-collaborative ways as a practical requirement of enacting leadership within these settings the nature of leadership in the sector more widely emerges as one that includes practices that are both in the spirit of (positive) collaboration, and those that seemingly go against this. This suggests that directive forms of leadership are required outside the confines of specific collaborations.

### 7.5 Summary of Discussion Chapter

This chapter has drawn attention to several themes that emerged during the research that go some way to answering the given research questions that will be considered more specifically in Chapter 8 – Conclusion. To preface that I will summarise the key aspects below.

Firstly, the role of the NHS as the convener and funder of the Wellbeing Erewash project meant that the voluntary sector had limited input into how the project was set up, the structures involved, and how it worked in a general sense. This finding is to be expected based both on previous research into voluntary-public sector working and into how collaborations function in practice. What this discussion does is contextualise these debates within a contemporary UK health policy context and highlights the ongoing gap between the policy rhetoric on one hand and what happens in practice. My research also lends empirical evidence to the concern in the voluntary sector literature that close working with the public sector is potentially damaging to the sector’s ‘comparative advantage’ (Billis and Glennerster, 1998) – its link to communities –
primarily through tensions created by organisations adopting the ‘transmission belt’ role, despite
the issue that most organisations will be unable to achieve this policy ‘ideal type’ (Albareda,
2018).

Secondly, the influence of the NHS as convener and funder of the project meant they maintained
a large amount of control over it. This included the extent to which voluntary sector organisations
and individual citizens were invested with positions in relation to the hierarchy of the project. In
particularly, Erewash Voluntary Action was named as the ‘lead’ organisation for the voluntary
sector within the project, which gave them some control – notably over information flows out to
the sector. However, this aspect of control was closely related to issues of power and trust which
act as “entangled twins” (Ran and Qi, 2018, p.624). Power and trust interact with control to
influence collaborative contexts (Bachmann, 2001) and within WE different traditions emerged in
relation to how personal and system trust and power were enacted within the voluntary sector as
opposed to the NHS at both micro and macro levels. This included different abilities to enact
change and/or shared trust that was sustainable over time, particularly related to personal
relationships. My research contributes to previous debates around trust, power, and control in
collaborative contexts by applying Bachmann’s notion of ‘traditions’ – previously used to
distinguish different national contexts – to the different sectoral practices of the voluntary and
public sectors.

Finally, my research identified the influence of hierarchy – notably in relation to clinical
professionalism – within the Wellbeing Erewash collaboration, suggesting that the ‘institution’
(Currie et al., 2009) of hierarchical leadership is dominant over attempts to distribute or share
leadership within the NHS. Although attempts to share did exist these were limited. This reflects
the traditions of system power and trust in public sector environments identified previously
within the project that was primarily controlled by the NHS. The voluntary sector was able to
‘make things happen’ within this context, reflecting previous research on leadership in
collaborative projects (Vangen and Huxham, 2003b). This stands in contrast to approaches to
leadership in the voluntary sector generally that suggest ‘collaborative’ approaches are exclusively
what would be deemed (by Vangen and Huxham, 2003b) to be ‘facilitative’ aspects – embracing,
empowering, involving, and mobilizing others. The involvement of the voluntary sector in more ‘directive’ aspects of leadership has implications more widely in the sector and may reflect a general leadership approach that is more dynamic and complex than previously considered, including the use of leadership that could be judged as ‘negative’ in relation to wider organisational or sectoral values. Alternatively, if the voluntary sector as a whole does conform solely to the positive aspects of collaborative leadership as described by Hodges and Howieson (2017) engaging in cross-sector collaborations presents a danger. The sector is faced with a need to compete in order to ensure organisational survival, combined with a need to act in directive or ‘thuggish’ ways in order to drive collaborative efforts forward and to be seen to be ‘good’ at collaboration. In this sense, more collaboration in policy may be making the sector less collaborative in practice even if it only serves to surface and make explicit leadership behaviours that are already there.
Chapter 8. Conclusion

8.1 Introduction to Chapter 8

In this final chapter, I will highlight the main contribution of the thesis through a focus on the research questions developed iteratively throughout the research process. Although the questions evolved over the course of carrying out the research – as is common in practice-based research approaches (Greenwood and Levin, 1998; Holliman, 2017; Harwood and Eaves, 2018) - answering them is important to capture the end point of this research process, crystalize the contributions, and to establish a basis for future research.

All academic research should focus on the impact it can make to practice and policy environments (Harwood and Eaves, 2018); as such, the theoretical contributions this thesis makes are themselves grounded in practical considerations. This approach also conforms with the adoption of Pragmatism as the driving ontological/epistemological force as detailed in Sections 4.2 and 4.3 of Chapter 4 – Research Design. The implications of the research cover theoretical, policy and practice areas in an interrelated way and so I will focus on these three aspects in combination.

I will also reflect on the approach of the research in relation to both the general methodology (Chapter 4 – Research Design), and analysis specifically (Chapter 5 – Analysis), in order to consider the strengths and potential limitations of the research design. There is no single, perfect way of doing research (Blaikie, 2000; Robson, 2002; Saunders et al., 2015) so it is important to be alert to alternatives, restrictions, and steps taken to mitigate the potential negative implications of chosen approaches. Finally, I will devote a section to discussing potential future research and the process through which this may be carried out.

8.2 Answering the Research Questions

The research began with an initial ‘research purpose’ (Wengraf, 2001) aimed at establishing the way the voluntary sector worked in practice in the Wellbeing Erewash (WE) project, as detailed in
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Chapter 4 – Research Design. Some initial reading of the academic literature suggested that an approach that considered WE as a collaboration would be beneficial (Huxham and Vangen, 1996; 2000a; Vangen and Huxham, 2003b; Vurro et al., 2011; Bryson et al., 2015); in addition, other research has drawn attention to the often subordinate role of the voluntary sector in working with public sector organisations, and the pressures that can come from this (DiMaggio and Powell, 1983; Billis, 1993; Carmel and Harlock, 2008; Milbourne and Cushman, 2013). As a result of the influence of this literature, several sub-questions were developed alongside the initial research purpose, that acted as cues for data collection, as Figure 4.1 on p.118 shows.

The three final questions structured the findings presented in Chapter 6 – Findings, and the subsequent discussion of these findings in Chapter 7 – Discussion. I will now return to these questions.

8.2.1 Question 1: What Was the Role of the Voluntary Sector in Wellbeing Erewash?

This first research question aims at a broad understanding of how the voluntary sector worked within the Wellbeing Erewash (WE) project. It is an extension of the initial ‘research purpose’.

Section 7.2 of Chapter 7 – Discussion, details the aspects of this thesis that are relevant to this question.

The Voluntary Sector had a place – through Erewash Voluntary Action – in the planning and delivery of WE. However, this role was different in practice to what had been promised in policy. The sector was missing from certain meetings and decision-making processes and was not an official named partner in any of the documentation produced during the project. These findings fit with previous research into public-voluntary sector working which suggests the voluntary sector is very much ‘subordinate’ in its role (Milbourne et al., 2003; also, Milbourne, 2013). Despite this ‘junior’ role, the voluntary sector did have an important position within the project due to the emphasis in policy on their role as ‘key partners and enablers’ of the New Care Models approach. Inherent in this was the assumption that the voluntary sector as a whole is linked closely into communities – it’s ‘comparative advantage’ (Billis and Glennerster, 1998) over other sectors. This assumption also allows voluntary sector involvement to be justified as an attempt to
address the ‘democratic deficit’ that has been present in the NHS since its founding (Benbow, 2018), and for the emphasis on ‘co-production’ in policy to be enacted in ways that reduce the risk and responsibility of NHS organisations. The emphasis involves a focus on both co-production with voluntary sector organisations themselves as representatives of communities, and with individual citizens. The voluntary sector in WE – through EVA – was therefore assumed to conform with both of these aspects and work as both a ‘voice for’ communities and a ‘route into’ them. This conforms closely with Albareda’s (2018) notion of ‘transmission belt’ organisations. This role can lead to tensions between organisations and individuals which crucially for the voluntary sector can include members of the communities they exist to support. This can in turn damage the very comparative advantage within the sector that formed the basis for their involvement in the first instance. These findings articulate the practice of a widely held concern in the voluntary sector literature – that closer involvement with the public sector risks ‘killing the golden goose’ of the sector itself. However, this position, although perhaps not ideal, is not entirely negative as the sector – EVA in particular – were able to leverage this situation in order to gain a far greater role in practice than they otherwise would have had – and have had in the past. In this sense, accepting this position within cross-sector collaborations with the public sector reinforces assumptions about the ‘strategic unity’ (Alcock and Kendall, 2010) which, although they may no longer be reflective of wider sector relationships (Rees and Kendall, 2016), do still have a legacy in practice. The acceptance of the ‘transmission belt’ role by individual organisations – who may not be able to carry it out – has to be couched in the context of competition present in public service delivery and the knowledge that if they do not accept the role then someone else will. The pressure on funding experienced by organisations under austerity politics makes this potentially a question of organisational survival.

The sector’s ability to carry out this role in practice would not seem to be as important as the fact they agree to it. My research shows this in how discussions regarding the outcomes of the project only emphasised the positive aspects. This is because collaboration itself is now a competitive arena and a ‘normative policy good’ (Osborne and Strokosch, 2013). In addition, as Macmillan (2013) has suggested, the concept of a ‘voluntary sector’ (and therefore the assumptions made
about it) is important to the practitioners within it. Maintaining this mythical notion of the voluntary sector role is supportive of this. There is relatively little accountability ‘upwards’ for the voluntary sector in the sense that the NHS does not seem to hold them accountable for achieving the ‘transmission belt’ role. However, the potential for this role to create tension and conflict between organisations and their members, service users, and communities means that care should be taken in considering accountability downwards.

8.2.2 Question 2: How Did Trust, Power, and Control Play Out in this Collaborative Context?

The issue of ‘control’ was a particular focus of the Wellbeing Erewash project, notably in relation to attempts to ‘give up’ control and move towards ‘bottom-up’ ways of working. Much like in relation to their overall role, the voluntary sector found themselves in ‘the middle’ of these attempts as typified in relation to the assumptions inherent in the ‘transmission belt’ ideal type. However, as this was invested in them by the NHS, ultimately the power to define this role existed outside of the sector, much in the same way the power of the community representative did. This power was inherent in the structures and processes of the NHS itself, from NHS England at a national level, to the local Clinical Commissioning Group. In addition to this, the concept of trust was treated as a policy goal in itself and there was a large amount of pressure within the project to be seen to be working in a way that reflected trusting relationships, particularly between the NHS and communities. The interrelated nature of trust, power, and control in this context reflects Ran and Qi’s (2018) notion that trust, and power are ‘entangled twins’ that act upon control. Furthermore, the differences between the NHS and voluntary sector in practice reflect different ‘traditions’ of trust and power, similar to those Bachman (2001) identifies between national contexts. Adopting Bachman’s lens of trust, power, and control in collaborative contexts also allows us to consider micro and macro aspects of power in an interrelated way, rather than as separate. Although there was primarily a mismatch between traditions of trust and power between the voluntary sector and NHS the interactions between the two sectors seen within the project hinted at the development of system trust through the structures and rules that were put in place. One participant noted the ‘assumed trust’ that they had felt they benefitted from as a
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result of previous work that had happened within the project. In addition, structures for engagement with the sector were established, although never tested (see Section 6.4.2).

Vangen and Huxham’s (2003a) research suggests it can take several years for collaborations to mature and, as Wellbeing Erewash was a three year project, the emergence of some of these aspects in the data collected during year three hint at part of this maturity being embedded in systems of power and trust. However, when the project came to an end, these structures were no longer used and as a result many of the aspects that could perhaps have developed in relation to system trust were lost. In addition, many of the personal relationships – and personal trust – that had been built up during the project were also lost as people moved onto different things. This is not uncommon in collaborative projects as Huxham and Vangen (2000b) have shown.

The treatment of trust as a ‘normative policy good’ (Osborne et al., 2016) ignores this complexity of interaction and the ups and downs of trust and power throughout the lifetime of a collaboration, and beyond. In addition, Milbourne (2013) has pointed out how rapidly changing environments interrupt the predictability of practices and security of shared rules, discourse, and values. These elements produce a ‘precarious’ environment for trust and “enable powerful agencies to impose arrangements that provide welcome anchors but are rarely mutually constructed.” (Milbourne, 2013, p.105). Considerations of power dynamics that have been emphasised as important in relation to collaborative working therefore need to include – and perhaps prioritise – the traditions inherent in the sectors that organisations inhabit.

The different traditions identified are not either ‘good’ or ‘bad’ in a normative sense however the dominance of the NHS – and therefore of system trust and power – means that working with the voluntary sector will be difficult. For the sector however, there were opportunities to exert aspects of personal trust and power, particularly in relation to personal relationships and in taking advantage of the less structured and rules-driven aspects of their practice in order to ‘get things done’ within the project. EVA in particular did have a choice in relation to (1) whether they chose to engage with the project in these instances, and (2) how they engaged, although some of these choices at times appeared contradictory. The concept of leadership offers a useful lens through which to consider this aspect.
8.2.3 Question 3: In What Ways Was the Voluntary Sector Able to Contribute to Leadership and ‘Make Things Happen’ in the Project?

Huxham and Vangen (2000a) have noted the lack of specific references to ‘leadership’ and/or ‘leaders’ in the data they collected to investigate the subject in collaborative contexts. In contrast, my research data contained a large amount of references to both, hinting at an increased emphasis on leadership in both policy and practice in the twenty years that separates their research from mine. This rise in profile for leadership is reflected in the ‘booming’ leadership development industry (Jackson and Parry, 2011) and the increased focus on leadership in academic circles (Alvesson, 2017).

Specifically, my research identifies the ways in which EVA were able to enact leadership in the form of ‘getting things done’ or ‘making things happen’ (Vangen and Huxham, 2003b) in Wellbeing Erewash – see Section 6.8.7 in Chapter 6 – Findings. This included developing and recruiting the ‘Community Connectors’ post; enabling the involvement of the ‘Community Representative’; preventing the duplication of work, such as that with carers; and in being selective in the aspects of the project they chose to engage with. EVA enacted this leadership role in the face of significant restrictions and limitations, including the role given to the single community representative as identified in Sections 6.6.2 and 6.8.4, and the ongoing system power of the NHS in their role as convener and funder of the project. Leadership within the project as a whole was dominated by hierarchical and authoritarian aspects, particularly in relation to the clinical professionalism inherent within the NHS, despite some attempts to enact distributed or shared leadership. This is the result of many of the aspects identified previously: the funding and convening role of the NHS; the lack of official partnership status for the voluntary sector, despite a presence in policy documents; and the different traditions of trust and power within the NHS and voluntary sector that impacted on an inability to ‘share’ control. This dominant hierarchy was also able to invest leadership positions in both EVA as a ‘named lead’ and in the community representative who was referred to as the ‘north star’ and ‘star citizen’ of the project by both local and national NHS employees. This worked in the favour of both EVA and the community representative however it was not entirely consistent – as shown in how EVA did not have a place
on the Alliance Leadership Team and how the community representative was not replaced when they disengaged with the project.

However, despite these wider aspects, EVA were able to enact leadership. This was mainly in relation to ‘making things happen’ in the project through working in both facilitative and directive ways. As such, they acted in a way that has been identified in the leadership studies literature as an ‘ambidextrous’ (Rosing et al., 2011; Zacher et al., 2014; Pina e Cunha et al., 2015) ‘hybrid’ (Gronn, 2009; Quick 2015) and ‘complex’ (Burns, 2002; 2008; Uhl-Bien et al., 2007; Uhl-Bien and Arena, 2017) approach in which different aspects of leadership are required, often at the same time. This is a crucial aspect of leadership in collaborative contexts (Vangen and Huxham, 2003b). EVA did this primarily through drawing on personal aspects of trust and power.

This need to act in more directive ways in enacting leadership sits in contrast to notions of leadership within the sector as a whole which emphasise working in the spirit of collaboration as broadly positive and inherent to the way the sector works (Howieson and Hodges, 2017). This also links back to wide debates about the ‘distinctiveness’ of the sector (Macmillan, 2013) and suggests the perceptions of practitioners do not match what happens in practice. As such, the emphasis on collaboration in current NHS policy as a ‘normative policy goal’ (Osborne and Strokosch, 2013), is potentially driving the sector to confront the more directive aspects of leadership, not in a negative sense but in order to work more effectively in these contexts. If we accept these previous assumptions as true then the practice of the sector risks being altered by this new emphasis. Alternatively, this may just be surfaced aspects of leadership that have always been a part of the sector but not widely acknowledged. Either way, questions emerge from this in relation to compatibility with wider organisational or sectoral values.

8.3 Contribution

As referenced at the start of this chapter, all academic research should focus on the impact it can have in practice and policy environments (Harwood and Eaves, 2018). My research emphasised relevance to practice as a key aspect of the overall design and the adoption of pragmatism as its philosophical base emphasises this focus. The contribution of my research therefore sits across
both academic and practice contexts and has implications for theoretical, policy, and practice
domains. The following section will consider all three of these domains together in relation to the
three themes of the research.

Firstly, in terms of theory, this research consolidates and extends Albareda’s (2018) notion of
‘transmission belt’ organisations. It adds empirical evidence in relation to how this role works in
practice. It focuses on a collaborative service delivery context in contrast to Albareda’s original
focus on policy influence. Furthermore, my research adds detail to the notion of
‘representativeness’ in relation to policy expectations, which links with traditions of co-
production. In identifying the tensions that can be created through this twin role, my research
also contributes to the voluntary sector literature that is concerned with the damage to the sector
that can be done through closer working with the public sector. Key to this is how aspects of
acting as a ‘transmission belt’ potentially damages the comparative advantage of the voluntary
sector – its link with communities through service users and other citizens. The important aspect
here is that through identifying specific elements of tension in practice my research
contextualises this concern and makes it more than an abstract notion. Practitioners therefore are
able to make an informed choice whether or not to be involved in this sort of role in collaborative
working with the public sector. Or – what is more likely in a context in which collaboration itself is
competitive and linked to funding – take steps to mediate this issue. There were hints in my data
that Erewash Voluntary Action was able to deal with this conflict and this offers the potential for
future research (discussed below). Because most organisations will not be able to fully carry out
the demands of acting as a ‘transmission belt’ voluntary sector practitioners should consider
whether they set themselves up to fail by accepting such a role. Surfacing the tension between
community representatives and the voluntary sector allows public sector practitioners to reflect
on the potential choices they make in a reflective way (Huxham and Beech, 2003). Policymakers
on the other hand should consider whether the demands placed on the sector are realistic and/or
implementable. Adopting collaboration as a policy goal creates a pressure to be seen to be
working in this way, despite an overall lack of effectiveness.
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The role of the voluntary sector as a ‘transmission belt’ also has implications for the literature around co-production and community engagement in the UK, particularly within a New Public Governance context that emphasises this approach. This literature suggests that a situation in which organisations are acting as representatives of communities is not uncommon, however, the literature does not identify the potential tensions that emerge from situations where co-production involves both individual citizens and organisations at the same time. There is an inherent assumption that they will be compatible. My research contributes by identifying the tensions created between individuals and organisations and suggests that an approach that emphasizes both will be very difficult to implement in practice.

The ongoing emphasis on competition, co-production, and collaboration creates contradictory demands that are almost impossible to meet. Paradoxically, this risks damaging the very aspect that public sector organisations seek to leverage by including the voluntary sector in policy goals (Macmillan and McLaren, 2012; Rees and Mullins, 2016). The presence of such paradoxical aspects is common in collaborative ways of working (Vangen, 2017). This finding has wider implications for the voluntary sector literature in relation to concepts of sector unity. In the mid-1990s, Leat (1997) suggested the idea of a coherent ‘sector’ had been invented to suit the interests of various parties, by the 2010s Alcock and Kendall (2010) were suggesting there was no one coherent notion of the sector and a ‘strategic unity’ was pushing a wider ‘sector’ narrative. In 2016 Rees and Mullins suggested this strategic unity was over and that the term existed as a symbolic tool. My research suggests that the definition of a ‘sector’ - in relation to work with the public sector at least – is determined by the assumptions inherent in policy documents, which are themselves a legacy of some of the ‘myths’ (Kendall, 2003) that contributed to the ‘invention’ of the sector. This is still a strategic benefit to organisations within the sector as it enables their involvement in public service delivery.

The second main contribution of this research concerns the relationship between trust, power, and control in voluntary-public sector relationships. It again contributes empirical evidence from practice to theoretical concepts that have been previously suggested in the academic literature. Section 7.3 of Chapter 7 – Discussion, provides greater detail in relation to this. Specifically, it
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takes the notion of ‘traditions’ of overlapping aspects of personal and system trust, power, and control originally suggested by Bachmann (2001) in relation to collaboration, and more recently Ran and Qi (2019) in relation to governance, as an explanatory tool for the ongoing difficulties around policy implementation found in practice as detailed in Section 6.2 of Chapter 6 – Findings. I suggest that the traditions of personal trust and power in the practices of the voluntary sector conflict with the traditions of system trust and power found in the NHS. This is not to say that one is better than the other as they both have potential strengths and weaknesses. Notably, this means that the voluntary sector does have some power in practice, a finding that may go against the perceptions of practitioners in the sector (Huxham and Vangen, 1996). Bachman’s approach also offers a way to approach power in collaborations that combines notions of macro and micro aspects in an interrelated way, allowing a more complete consideration of such contexts. This contribution is particularly important for practitioners as shared experiences cannot be assumed to lead to shared understandings. Individuals and organisations within the voluntary sector had far more autonomy to directly influence practice in their organisations than their NHS counterparts, meaning that a shared commitment to - for example - ‘work differently’ within the project was enacted in contrasting ways. NHS staff often did not have the power to change their ways of working because of structural restrictions in ‘the system’ – such as reporting targets or contract agreements – and as a result were not able to give up any power because it was invested in these structural aspects, rather than in them as individuals. Knowledge of this difference between traditions can both help to reduce frustrations around policy implementation - which are a common refrain from voluntary sector workers in practice - and lead to better solutions to ongoing problems. Despite these differences, system power and trust dominated the Wellbeing Erewash project. The traditions inherent in the public sector help to explain this and also may go some way to explaining the ongoing preferences in funding arrangements to work with larger organisations who may display aspects of system power and trust (structures, procedures, rules etc.) that are similar to the NHS and wider public sector. Policymakers and practitioners therefore need to consider sector traditions alongside other notions of trust and power in order to leverage the
aspects of both that can lead to closer ways of working. A practical example of this that was found in the research is providing voluntary sector organisations with NHS email addresses. There is significant system power inherent in this that is then passed to the voluntary sector. This finding also contributes to debates around whether there is something ‘unique’ about the voluntary sector, or rather, about the practices found within voluntary sector organisations. There does appear to be a difference, particularly in comparison with the NHS. An acknowledgement of the ability voluntary sector organisations have to share power and control with communities is a great positive within public service delivery. However, there is a risk that working in such a way does not just lead to a sharing or boosting of power with others but a giving up of power and control to them, or to collaborative entities themselves (Vangen and Huxham, 2003a) which, as we have seen with WE, are likely to be controlled by those convening and funding them. Policy makers and practitioners should therefore attempt to find ways to involve the voluntary sector as conveners of collaborative projects, in order to counteract the public sector’s role as the primary funder. Brinkerhoff and Brinkerhoff (2002) suggest this will make ‘bottom-up’ interactions and community empowerment more likely. This also conforms with Follett’s (1925) notion of ‘growing’ power, rather than it being a finite resource that has to be shared. Conceptualising power in this way means that the NHS can keep their existing power, but the voluntary sector can be enabled to grow theirs. A case can therefore be made to acknowledge the role of the voluntary sector more formally in policy and resource it specifically in practice to enable a more robust approach to sector and community representation. However, care should be taken not to ‘professionalise’ engagement with the sector in the same way patient representation has been in the NHS (Thompson et al., 2012; El Enany et al., 2013).

The final contribution this research makes is in relation to the voluntary sector’s ability to enact leadership in collaborative settings. Previous research has identified the leadership role that voluntary sector organisations can play in cross-sector collaborations (Huxham and Vangen, 1996; Windrum, 2014), particularly in relation to the notion of ‘making things happen’ (Huxham and Vangen, 2000a; Vangen and Huxham, 2003b) in a practical sense. This thesis adds contemporary empirical evidence to this and draws attention to the voluntary sector’s collaborative work with
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the NHS specifically, contributing to the growing focus on this area (Peate, 2013; Turner et al.,
2016; Rees et al., 2016; Newbigging et al., 2017). In addition, this research draws on the
collaboration literature to contribute to the wider discussion around the impact of collaborative
leadership practices on voluntary sector organisations. Specifically, that the use of collaboration
as a ‘normative policy goal’ forces voluntary sector organisations into specific working
relationships that are convened, funded, and therefore controlled by the public sector, in order to
remain relevant and secure ongoing funding.

As leadership in collaborative settings requires both facilitative and directive approaches (Vangen
and Huxham, 2003b) – often at the same time – this offers a challenge to wider conceptions of
leadership within the voluntary sector which have emphasised the more facilitative aspects of
collaboration in the guise of ‘positive’ approaches – inclusion, enabling others, sharing values etc.
that both fit with wider historical ‘myths’ of the voluntary sector and with organisational values.
However, in practice, focussing on collaborative contexts shows how leadership within the
voluntary sector is far more complex and includes behaviours that may be viewed in a normative
sense to be ‘negative’ but are justified in achieving collaborative aims. For practitioners, care
should be taken to only enact approaches to leadership that are appropriate in given settings;
falling to do so may result in damage to positive relationships both within and outside the sector.
In addition, sector organisations must also consider whether the leadership approaches they are
enacting fit with wider organisational values.

Leadership can be used by the voluntary sector to play an active rather than passive role in
environments in which they have less power. EVA were able to ‘get things done’ in spite of the
restrictions both within and outside of the WE project. For EVA this amounted to the ability to
generate additional funding, recruit more staff, and raise the profile of the sector. An
acknowledgement of this positive aspect of leadership for practitioners will enable not only more
opportunities to be taken but also more of a focus on what the sector can do within collaborative
environments rather than what they can’t. This in turn will drive a wider conception of leadership
beyond hierarchy and simple top-down ideas of power relations. Such a wider conception of
leadership will also benefit policymakers and encourage them to stimulate future service design
which enables diverse aspects of leadership in a way that is not tied to unrealistic notions of ‘sharing’ or ‘giving up’ power that ignore different traditions across sectors.

8.3.1 Summary of Contribution

To summarise, we can conclude from the research that the voluntary sector still finds itself in a marginal role within cross-sector collaborations, despite positive messages in policy, planning and the espoused positions of practitioners. However, there are ways the sector can contribute within this seemingly restricted role. The more pessimistic conclusion emerges if we consider the tensions created by the transmission belt role, the impact this can have on the sector’s ‘comparative advantage’, and that most organisations are in a position where they will be unable to enact this role in practice; the ongoing dominance of the NHS (and other public sector bodies) in relation to their position as funder and convener of collaborations; the difficulties in resolving competing traditions of trust and power; and the influence of hierarchy in relation to leadership, particularly as regards clinical professionalism. Further, as previous research into leadership in the voluntary sector has highlighted the positive (facilitative) aspects of ‘collaborative’ approaches, and these form part of the wider assumptions about the sector in the literature, policy, and practice, the sector is faced with two potential implications. Either the assumption is true in which case the increased involvement of the sector in collaborative contexts which have been shown to require alternative leadership approaches risks altering the inherent characteristics of the sector, or the assumption is not true and involvement in collaborations risks damaging relationships between sectors by highlighting this inaccuracy in practice.

More optimistically, the ability of EVA in particular to ‘make things happen’ in the project offers some hope for voluntary sector organisations working in similar contexts. EVA were able to enact leadership despite what would appear from the above to be quite significant restrictions. Additionally, knowledge of the transmission belt role provides organisations with a way to conceptualise and mediate for the potential damaging impacts of the tensions generated and/or the confidence to refuse to adopt a role that they cannot fulfil; identifying competing traditions of trust and power both strengthens claims to the ‘uniqueness’ of the voluntary sector and allows
for positive steps to be taken in relation to addressing the difficulties of working together in a cross-sector way; and the potential to enact different forms of leadership provides a tool that can be used for positive impact in practice.

### 8.4 Reflections on Research Approach

To continue the focus on reflexivity emphasised in previous chapters, this section reflects on the strengths and potential limitations of the overall research design.

The approach taken within this research had several advantages. In particular, the focus on practice allowed me to emphasise what participants actually did – their ‘theories-in-use’ (Argyris and Schöen, 1974) - rather than solely working backwards from outcomes or relying entirely on what participants said about their own actions – their ‘espoused theories’ (Argyris and Schöen, 1974). Approaching the data in a way that adopted the concept of ‘triangulation’ from Research Oriented-Action Research (Eden and Huxham, 1996; 2006; Eden and Ackerman, 2018) allowed for a variety of data that represented all of these different aspects to be integrated during analysis. This broad approach to data collection allowed for a ‘thick description’ (Geertz, 2005/1972) of the research context. This sets my research apart from others that have previously investigated the role of the voluntary sector in relation to the public sector that rely either primarily on interview data (Neville, 2010; Rees et al., 2016; Hemmings, 2017) or, even when attempting in-depth qualitative research, do not consider impact in practice (for example, Milbourne, 2013). The approach also allowed me as the researcher to take part in the research context as a participant, and to enact interventions. This role necessitated significant reflection in order to attempt to combat the bias that can exist. Sections 4.8 and 5.4 detail this use of reflexivity. In a broader sense, adopting pragmatism as the ontological and epistemological basis of this research allowed me to focus on what happened in practice and enabled an approach that was not distorted by attempts to ‘fit’ the research into a certain ideological position. This lack of ideology enabled me to surface conflicting notions in the data without attaching a normative value to them. We can see this in my findings in relation to the equal validity of system and personal trust and power, in the lack of normative judgement in relation to the ‘transmission belt’ role, and in relation to the
acceptance of both facilitative and directive forms of leadership. These seemingly contradictory or paradoxical elements are more accurate reflections of the practice of cross-sector collaborations. Despite the strengths of this approach, there were also limitations, as is the case in all research (Blaikie, 2000; Milbourne, 2013). Comparison with other approaches is difficult, due to the contextual and temporal aspects of the research, my role as the researcher, and the specific project that was studied. All of these aspects existed uniquely at the time of the research and are very unlikely to do so again. However, a focus on practice means that aspects from the research can be generalised if and when they are relevant to other areas of practice, both in the short or longer term. There are also generalisabilities based on findings that contradict previous positions in the literature, such as in relation to notions of leadership in the voluntary sector. Another aspect that has acted as a limitation of the research is the speed of change experienced in practice. At the beginning of the research I had a stated aim to attempt to both intervene in a way that was supportive of practitioners and to produce findings and suggestions that would be useful in the practice context. Unfortunately, the turnover of staff and the way the project ended has meant that the recommendations I can make are less specific than would have been ideal. Despite this, the findings have been well received by participants and certainly offer more general insights that can have an impact in the changing research context. In addition, the ongoing importance of the ‘wicked problems’ that the Wellbeing Erewash project attempted to address, and the policy emphasis on collaboration as a specific goal means that a similar or related context is likely to be created in the near future.

The immediacy of the access I enjoyed for the purposes of data collection allowed for the use of an engaged research methodology with supportive participants, in a context I was familiar with. This is a relatively rare opportunity in academic research and so the snapshot that the research provides exists as a unique dataset in comparison to official evaluations of the project and other academic studies into voluntary sector-NHS collaborations. Working as a ‘lone researcher’ could be viewed as limitation on any research findings, due to the bias of my axiology. By making this explicit in Section 4.4 I hope to have gone some way towards mediating this issue. The support I
had throughout the research either through formal supervision or informal conversations with academic colleagues and research participants meant that I was never truly alone in the research. The dominance of the NHS that has been identified in the findings of this research can also not be ignored in relation to the impact it had on the research process itself. Because of this dominance I was exposed to a large amount of NHS practice and as a result, top-down structures and processes, along with formal hierarchy and clinical approaches were highly present in the data. I also specifically sought out more of the NHS context during the second half of my data collection by adapting my approach (see Section 4.7 – Methodology) which upon further reflection may have been because of the pressure I felt as a researcher to capture more from the NHS as the dominant partner.

Alternative approaches also exist within engaged research traditions. The research could have been more participatory; have taken place over a longer time period; included more distinct interventions; and involved more participants. Practicalities restricted this and so a pragmatic decision was made to carry out the research in the way that it was. Focusing on capturing as much data from the practice environment as was possible under these restrictions is enough to say the research was ‘practice-based’. Improvements to the research design could have been made, such as using participants as co-researchers and thus developing an ‘inquiring community’ (Reason and Torbert, 2001). Unfortunately, I did not have the time, knowledge, or experience to attempt this alongside the data collection

The pressure to capture data before the end of the project meant that I was ‘in the field’ only six months after starting my PhD study. This gives rise to another aspect that could have led to even richer research findings – the time period over which data collection took place. Ideally, I would have collected data from the whole life of the Wellbeing Erewash project however I was only able to directly capture data on the final year. Kramer (2018) suggests collaborations do vary over time and so aspects of this variation may not have been captured. Despite this, some data from previous years was available to me through the records kept by others and this gave me some useful points of comparison to the data I collected directly. Additionally, I was able to identify
some significant change within the data that relates to the overall life of the project as a whole, such as discussions around sustainability, that conform with Kramer’s (2018) suggestions. A final limitation exists in relation to the differences within both ‘the voluntary sector’ and ‘the NHS’. Both are far more complex than they are at times treated within this thesis. These complexities should not be underplayed; and my research does not attempt to suggest its findings are applicable to all voluntary sector, all NHS, or all voluntary sector-NHS contexts. Rather, it makes the case that there will be contexts in which they are relevant, and this will particularly be the case when structures and processes are similar, as they tend to be in contexts mandated by strong public sector policy directives. It’s important to emphasise that engaged research approaches – particularly those influenced by action research – take years to perfect and to generate the deep theoretical insights that are suggested in the approach (Coghlan and Brannick, 2010; Eden and Ackerman, 2018). Therefore, my research is a start along this journey.

8.5 Potential Future Research

The findings of this research suggest several interesting areas that could be pursued through future research. Firstly, the identification of the pressures experienced by Erewash Voluntary Action (EVA) as a ‘transmission belt’ organisation deserves further attention. For instance, is the fact EVA is an infrastructure organisation a deciding element in this experience in practice, or is it related to the specific role that they had within the Wellbeing Erewash (WE) project? Is this experience consistent in other contexts? The pressure to engage with communities also leads to the question of how this is managed more generally, some of the data within the research hints at the ability of the voluntary sector to successfully manage the tensions that come with this engagement role; further research into this would be very valuable both in relation to the contribution to theory around co-production and engagement that this could make but also in relation to practical advice for managing this effectively. As trust and power have been identified as acting upon control, but were found to have been largely ignored in practice, does a more open discussion of different trust/power traditions alter how voluntary-NHS collaborations work in practice? As practitioners seemed more comfortable with the notion of ‘control’ is using this
terminology more effective in enabling these conversations? Further, the potential role of voluntary sector organisations as conveners of collaborations would be particularly interesting to explore.

As with most qualitative research, comparison with other research contexts is needed, particularly in relation to more recent NHS policy interventions, such as Primary Care Networks, Integrated Care Systems etc. (NHS, 2019a). One question that arises from the voluntary sector being excluded from the official evaluations of WE and from the ‘story’ told of the project - as described in Section 6.2.5 – is whether project evaluations play any role in relation to policy development. Tracking learning from a local to national level, through NHS policy structures would provide insight into this.

In relation to leadership, the suggestion that collaborative leadership in the voluntary sector may actually be altered by mandated collaboration should be of particular concern to academics, policymakers, and practitioners alike. It warrants further, more detailed attention, particularly in relation to the balance within collaborations between facilitative and directive leadership, when enacted in practice by voluntary sector organisations. Future research should investigate the impact on leadership in practice when collaborative efforts are initiated from the top-down – as in Wellbeing Erewash with the role of NHS England – or truly from the bottom-up, growing from communities and the voluntary sector. This work would also help to address the ongoing dearth of research in relation to leadership in the sector which endures despite the large and growing interest in, and commitment to, the subject in practice. Specifically, does approaching the sector as a whole through the lens of collaborative leadership and ‘making things happen’ offer more insight into the practices of the sector?

Finally, the legacy and sustainability of ways of working in practice is a particularly interesting area to explore in future research. Anecdotal evidence gathered through my visits to Erewash since Wellbeing Erewash came to an end suggests that in the initial aftermath many of the links between the voluntary sector and NHS broke down, individual relationships were lost, and many of the structural aspects such as meetings and events did not continue. However, more recently, relationships have improved and some of the previous ways of working that were established
within the project have re-emerged, albeit in slightly different forms. This gives rise to questions about how long it takes to ‘get back’ practices when they are removed, and whether there may be positive short and long-term benefits to collaborative working but negative medium-term impacts; a vacuum created when projects end. Perhaps the skeleton of system power and trust remained in the aftermath of WE, despite not initially being utilized. Longitudinal research into other time-limited projects in both NHS and non-NHS contexts, particularly in the years after they end would help to answer this question.

There is also still much to explore in the data collected during this research and further analysis offers the potential for additional insights. In particular, much of the thesis refers to concepts that focus on the interplay between systems and people – or alternatively between structure and agency. Examining this through the lens of Giddens’s (1984) ‘structuration theory’ may offer additional contributions to both the academic literature and to practice.
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Appendices

Example Interview Prompts

1) Please explain your role in, or connection with, the Wellbeing Erewash project

2) How long have you been involved and has your position changed over time?

3) Who do you think has ownership of the project?

4) How have you seen the role of the voluntary sector in the project?

5) How have you seen the role of Erewash Voluntary Action in particular?

6) What has worked well in the project?

7) What have been some of the challenges in the project?

8) What do you anticipate being the future of the project? Is it sustainable?

9) Any final comments?
Figure 8.1 - Description of Erewash Voluntary Sector Forum

Introduction:
The Erewash Voluntary Sector Forum (EVSF) will be a network open to all voluntary organisations operating in the Erewash Area (1). It will provide a space for those organisations to meet and exchange information, ideas and good practice. The EVSF will work to strengthen the voluntary sector within Erewash and to develop a cohesive and articulate voluntary sector body.

Aims
The Erewash Voluntary Sector forum will operate as a strategic platform to influence and raise concerns and issues facing the voluntary sector.

Objectives
- Campaign, promote and develop new ways of communicating and working with public and private sector agencies.
- Ensure that the collective views of the voluntary sector are considered, influence and affect planning and policy decisions.
- Develop collective views and promote the interests of the voluntary sector in Erewash
- Enable the sharing of experiences, good practice, skills and resources and to provide a platform for organisations to raise issues and gain mutual support
- Build the capacity of the voluntary sector to work together on common issues.
- Develop and initiate discussions with commissioners.
- Promote the diversity and value of the voluntary sector
- Build effective partnerships with statutory and private sector organisations.

Values:
- The EVSF will support and be accountable to the voluntary sector and will clearly explain the mechanisms in place.
• The EVSF will be non-party political

• The EVSF will be committed to equal opportunities and anti-discriminatory practice.

• The EVSF will maintain a positive environment for discussion

Who should attend:

Any voluntary organisation (1) working in the Erewash area.

Ways of working:

Not less than 4 meetings per year. Additional meetings may be requested by the group.

Group members will be encouraged to raise agenda items for future meetings.

Evaluations will be carried out at all EVSF meetings.

EVSF will be reviewed on an annual basis.

Erewash Voluntary Action will provide the administration of the EVSF

Agendas will be circulated 7 days prior to the meeting.

(1) By ‘Voluntary Sector’ we mean any constituted voluntary organisation including groups registered with the Charity Commission and/or Companies House, independent of (local or central) government.

(Source: EVA, 2017b, © Erewash Voluntary Action, used with permission)
Figure 8.2 - Description of Erewash Development Workers Forum

Erewash Development Workers Network

Introduction

The network will be open to all development workers operating in the Erewash area. It will provide a space for these workers to meet and exchange information, to learn about services on offer.

Aims

The network will bring together individuals who support clients in the Erewash area to share skills, information, experiences, good practice and resources.

Objectives

- Provide a platform for individuals to share the work they are delivering
- Enable the sharing of information and good practice.
- Provide and disseminate information
- Improve the shared understanding of each other’s work and projects
- Identify gaps and duplication in services
- Identify issues affecting the delivery of services and how these may be addressed collectively

Values:

- The Development workers network will be non-party political
- The Development workers network will be committed to equal opportunities and anti-discriminatory practice.
- The Development workers network will maintain a positive environment for discussion
Who should attend:

Any development workers (1) in the Erewash area.

Ways of working:

Not less than 4 meetings per year. Additional meetings may be requested by the group.

Group members will be encouraged to raise agenda items for future meetings.

Evaluations will be carried out at all Development workers network meetings.

The Development workers network will be reviewed on an annual basis.

Erewash Voluntary Action will provide the administration of the Development workers network.

Agendas will be circulated 7 days prior to the meeting.

(1) Development workers network includes people working/volunteering in a community development role and people who deliver front line services including Statutory/private/voluntary sector workers.

(Source: EVA, 2017c, © Erewash Voluntary Action, used with permission).
Figure 8.3 - Wellbeing Erewash Infographic

Wellbeing Erewash – making a difference

Wellbeing Erewash is one of a number of places around the country - known as NHS England ‘vanguards’ - looking at new ways of improving people’s health and wellbeing. It involves the people of Erewash, the local NHS, social care and the voluntary sector.

The aim is to encourage thriving communities within Erewash, where people feel confident and supported to choose a healthier lifestyle, stay well, and know how to get help and support when needed.

Changing demographics

In Erewash by 2020

21% of the population (22,000) will be aged over 65

↑ an increase of 17% from 2013

3% of the population (3,500) will be aged over 85

↑ an increase of 33% from 2013

Enablers

We have been helped in our work by a number of contributing factors, these included:

- Strong GP engagement and leadership
- Multi-agency working (including primary care, community services, adult care, local authority, commissioners, voluntary sector)
- Clear vision
- Citizen engagement
- Population insight
- Trust
- Financial investment from NHS England

(Source: adapted from Wellbeing Erewash, 2018*)
**Figure 8.4 - Erewash Place on a Page**

To provide person-centred care through efficient pathways, by working together with communities and services that impact on health and wellbeing.

People with long term conditions will be able to manage their condition with support from family, specialist befrienders, social and primary care. Individuals will have a shared care plan that sets out how to stay well, but also what happens in a crisis. This will result in a reduced reliance on expensive models of care and will be supported by evidence based therapy and wellness services. Individuals will live in appropriate housing with assistive technology supporting them. Individuals will end their lives in the place of their choice with the people they wish to be with. When individuals need hospital based care this will be planned and for a short time, with a clear discharge plan from the moment of admission, to ensure that they get back to the place they call home as soon as possible.

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(Source: Erewash CCG, 2018*)