Local status and power in area-based health improvement partnerships

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Abstract

Area-based initiatives (ABIs) have formed an important part of public policy towards more socio-economically deprived areas in many countries. Co-ordinating service provision within and across sectors has been a common feature of these initiatives. Despite sustained policy interest in ABIs, little empirical work has explored relations between ABI providers and partnership development within this context remains under-theorised. This paper addresses both of these gaps by exploring partnerships as a social and developmental process, drawing on concepts from figurational sociology to explain how provider relations develop within an ABI. Qualitative methods were used to explore, prospectively, the development of an ABI targeted at a town in the north west of England. A central finding was that, although effective delivery of ABIs is premised on a high level of coordination between service providers, the pattern of interdependencies between providers limits the frequency and effectiveness of cooperation. In particular, the interdependency of ABI providers with others in their organisation (what is termed here 'organisational pull') constrained the ways in which they worked with providers outside of their own organisations. 'Local' status, which could be earned over time, enabled some providers to exert greater control over the way in which provider relations developed during the course of the initiative. These findings demonstrate how historically constituted social networks, within which all providers are embedded, shape

partnership development. The theoretical insight developed here suggests a need for more realistic expectations among policy makers about how and to what extent provider partnerships can be managed.

Keywords: partnership, collaboration, community services, area-based initiatives, organisational pull, figurational sociology

Introduction

Initiatives targeting geographical areas of relative deprivation (area-based initiatives – ABIs) have been a consistent feature of public policy within Western countries in recent years (Randolph, 2004, Bradford, 2007, Larsen and Manderson, 2009, Berkeley and Springett, 2006). Since 1997 in particular, a central feature of ABIs in the United Kingdom (UK) has been an emphasis on co-ordinating service provision within and across sectors through various partnership arrangements (Sullivan et al., 2006). These partnerships have generated considerable research interest, which has revealed consistent difficulties in their development (Benzeval, 2003, O'Dwyer et al., 2007, Judge and Bauld, 2006, Beatty et al., 2010). Despite this attention, the experience of ABI partnerships remains under-theorised, limiting the extent to which the difficulties reported in the literature can be explained. Although inter-organisational relations have been examined in detail in the fields of business and healthcare (Aveling and Martin, 2013, Dickinson and Glasby, 2010), ABI partnerships in public health present a set of specific issues given that they usually involve a large number of organisations working towards disparate aims within the confines of a time-limited intervention.

This paper offers some empirically grounded theoretical insights into partnership processes among service providers within ABIs in order to shed light on why collaboration often remains elusive. It presents findings from a case study of an ABI delivered between 2007 and 2012 in a town in the north west of England. Target

Wellbeing (TW) was a BIG Lottery funded initiative targeted at 10 geographical areas of health 'disadvantage' across the North West, defined as such by initiative co-ordinators according to levels of self-rated physical and mental health, obesity rates, fruit and vegetable consumption, incidence of coronary heart disease and benefit claims (name withheld, personal communication, 2007[1]). The multi-sector providers co-ordinating TW intended to improve the health and wellbeing of residents via a programme of activities in targeted areas. Each programme was made up of 8-10 projects designed to improve one or more of the following: healthy eating, physical activity and mental wellbeing. The projects were delivered by a range of voluntary and statutory organisations and each programme was managed by a lead organisation and a designated TW co-ordinator. Figure 1 shows the management structure for TW.

The specific question this paper examines is, how do relations between service providers develop over time when an ABI is introduced in an area? Ideas from figurational sociology were drawn on to conceptualise ABI collaborations as a figuration of interdependent people. The paper starts with a brief review of the literature on service provider relations within ABIs before introducing concepts from figurational sociology that were used to inform the research. The methodology is then described and the findings presented, describing and explaining the social processes that shaped co-ordinated working over time. The discussion examines how figurational sociology facilitated a more adequate understanding of the ways in which ABI partnerships develop and considers some of the policy and practice implications of our conclusions.

The rhetoric and reality of provider collaboration

[1] Names have been withheld to protect the anonymity of research participants

Since the late 1960s successive UK governments have shown considerable interest in co-ordinating service provision through ABIs (for a brief overview see Burton, 1997, Stewart, 2001). The Labour Government of 1997-2010 argued that the health of people living in deprived areas could be improved through, among other things, better co-ordination of, and improved access to, services (Department of Health, 2004, National Institute for Health and Clinical Excellence, 2008, Department for Communities and Local Government, 2006, Department of Health, 2001). Co-ordination of local public services was a core feature of many Labour-funded initiatives including Health Action Zones (HAZs), Sure Start and New Deal for Communities.

The Government claimed that the causes of worse health and social outcomes in deprived areas were interconnected and therefore required the co-ordinated expertise of a range of providers (Blair, 1997). HAZs, for example, were seen as vehicles for innovating services by encouraging providers to work outside of their professional boundaries in the delivery of projects seeking to promote health (Bauld et al., 2005). Although there have been fewer government funded initiatives under the current Coalition Government, interest in local co-ordination of services has remained (Department of Health, 2010). Despite sustained policy interest, research indicates that ABI partnerships have not been implemented according to the expectations of policy makers (Berkeley and Springett, 2006) and that co-ordinated working between providers within ABIs has been limited (Hunter and Perkins, 2012). Some of the problems with partnership development reported in empirical studies are discussed below.

Partnerships as social processes

Much of the work on ABI partnerships has focussed on identifying “factors” that influence partnership development (Wildridge et al., 2004, 6) or, as Dowling et al.

(2004) have argued, on the identification of barriers to implementing planned action. For example, differences in the governance structures of organisations across different sectors were identified as barriers to collaboration in the strategic development of HAZs (Unwin and Westland, 2000), but are the ways in which governance structures are established, maintained or challenged through human interaction within an ABI partnership are not understood. Similarly, several studies have shown that competition for funding between service providers within ABIs can undermine capacity for collaborative working (Milbourne, 2009, Carlisle, 2010) and that such competition can exacerbate “fear of outsiders” among service providers (Milbourne, 2009, 287). While such work is important in identifying problems in partnership development, we would argue, for the reasons set out below, that none of this work provides a model which offers an adequate understanding, on a more theoretical level, of the processes involved. We would further argue that such a general model is required for, without a continual interdependence – what Elias referred to as “an uninterrupted two-way traffic” (Elias, 1987:20) – between the development of detailed knowledge and synthesising models, the collection of detailed knowledge of particular situations will be of limited use, for it is only by the use of synthesising models that we can generalise from one situation to another.

The limitations within the ABI literature can partly be explained by the focus on strategic partnerships between service co-ordinators at the regional or city level (Beatty et al., 2010, Carlisle, 2010, Henderson, 2011, Sullivan et al., 2006). This has directed the focus of research towards management and leadership issues within ABI partnerships and has deflected research attention from the social relations that develop between those involved in service delivery, which is central to our purposes in this paper. Checkland et al. (2009) suggest that more attention is needed on the social conditions that create barriers to implementing policy. Examining the ways in which providers have become interdependent with others over time, including

colleagues and professional peers, might facilitate a better understanding of the ways in which they are constrained in their capacity for collaboration by emotional involvement in a particular set of relations. Pawson and Tilley (1997, 70) draw attention to the fact that social interventions are "introduced … into an existing set of social relationships." However, there has been a tendency within ABI evaluations based on a realistic methodology to view provider relations as static (Barnes et al., 2003). Furthermore, the cross-sectional study design of many ABI evaluations has meant that health partnership processes are often depicted as linear and predictable (see for example Boydell and Rugkåsa, 2007, Lawless, 2002, Wholey et al., 2009). Asthana et al. (2002) identified a framework for evaluating HAZs, distinguishing between context, inputs, processes, outcomes and impacts. This framework, however, does not identify the connections between these elements, failing to recognise the complex ways in which these social processes are interrelated. Changing social relations (between those involved directly in the partnership and a range of others on the periphery) and their influence on the development of partnerships have not been adequately accounted for thus far. As Sullivan et al. (2006) note, researchers have struggled to explain how partnerships are influenced by unplanned events within, what is described as, the wider social context of the partnership. The influence of national policy changes on local-level partnerships (Beatty et al., 2010) suggests that the social networks in which ABI providers are embedded, beyond the immediate partnership, are likely to shape the way in which they work with other providers.

Although the everyday microdynamics of partnerships have been researched and reported – as illustrated in the above examples – they have not been adequately understood. This is partly because the everyday relations can only be understood when contextualised within broader, longer-term social processes. The literature indicates that there is no straightforward causal relationship between strategic

aspirations for partnerships, planned activity and outcomes. Examining prospectively, as we do here, the planned and unplanned outcomes in an ABI, and the processes that connect them, provided an opportunity to develop understanding about processes of co-ordinated working within an ABI. Some key concepts within figurational sociology, which informed our theory of partnership development, are discussed below.

Theorising service provider collaboration in public health ABIs

Figurational sociology, a perspective which has been used to examine organisational change within the NHS (Dopson and Waddington, 1996, Mowles, 2011), has not been applied to the field of public health in general or ABIs in particular. Its central focus is the networks of interdependency (or figurations) in which people are embedded. These figurations are produced by the interweaving actions of large numbers of people who are both enabled and constrained by those figurations (Elias, 1978, Elias, 1991). Service providers within an ABI are interdependent with (at the least) other local and national providers, funders and policy makers, and their capacity for co-ordinated action is therefore both facilitated and simultaneously constrained by the actions of those people. Planned public health ABIs, therefore, are likely to produce consequences which no group or individual intended (Elias, 1994). Examining the figurations in which service providers are immersed presents an opportunity to explain why providers have been constrained in their capacity for collaborative working.

A central dimension of figurations is power, conceptualized not as a substance possessed by particular individuals or groups but as ‘a structural characteristic of human relationships’ (Elias, 1978: 74). Power is never absolute but always a question of relative balances, for no-one is ever absolutely powerful or absolutely powerless. Power balances are also inherently unstable and continuously in flux.

While most sociological perspectives draw attention to power relations, conceptualising an ABI partnership as a figuration of interdependent service providers draws attention to the ways in which their interdependencies are characterised by different balances of power. Where there are heavy imbalances of power, for example in relation to the professional status of providers within a cross-sector group, some parties might be better able to exert more control over events than others. Based on empirical examination of resident relations within a small town, Elias (with Scotson) (1965) argued that power balances within a figuration could be influenced by one's status as either 'established' or 'outsider'. The introduction of a new set of projects into a small town as part of an ABI has much in common with the social changes examined by Elias and Scotson (1965). Observing caution that the 'established-outsider' concept might dichotomise the experiences of different groups (see Bloyce and Murphy, 2007), it might usefully be applied to examine power relations between providers in a small town.

Finally, for the purposes of this paper, figurational sociology encourages analysis that incorporates the historical context of social relations within an area. Elias (1991) argued that because social phenomena emerge from interweaving human actions, it is impossible to locate their origins to any precise 'moment' in time. The interweaving actions result in dynamic interdependencies and shifting balances of power between people over time. However, Elias also perceived that over time a person's place in a network of relations with others strongly influences her/his disposition, tastes, ambitions and expectations (Elias, 1991) or what he described elsewhere as habitus (Elias, 1996). Examining social processes prospectively, and thus developmentally, therefore has the potential to better explain unplanned events. Again, figurational sociology is not unique in pointing to the importance of historical context, but offers 'a set of sensitizing concepts … with the potential to draw many of the various threads of sociological thought together' (van Krieken, 2001, 353).

Methodology

A longitudinal, qualitative case study design was used to examine relations between service providers within a single town ('Seatown') targeted by TW. This provided an opportunity to trace the links between particular events (Maguire, 1988) in order to generate theoretical generalisations about the social conditions that shape partnership development (Yin, 2003, Dopson, 2003). The study had a commitment to a grounded theory approach (Strauss and Corbin, 1998) while also testing out a number of figurational ideas, using them as sensitising concepts as outlined above, to maintain a two-way relationship between inductive and deductive processes (Elias, 1978).

Ethical approval for the study was gained in May 2009 from a regional National Health Service research ethics committee. Non-participant observation of 52 TW activities was conducted between May 2009 and May 2012 to capture unfolding social relations between providers. These activities included quarterly meetings between TW providers and TW co-ordinators in Seatown, a local area partnership board meeting and a range of activities at each of the eight TW projects. Observations were used to capture the dynamics of the relationships between providers as well as any unplanned consequences of planned activities, as Elias (1978) advises. In addition, documentary analysis of the TW funding application, local service meeting minutes and quarterly project reports to funders was conducted to further explore how relations between providers developed over time. Examining these documents provided an opportunity to examine the small-scale TW provider figuration in the context of wider figurations in which it was developing. For example, TW meeting minutes drew attention to the influence of local government re-organisation on TW provider relations.

Nine months into the ethnographic fieldwork 32 semi-structured interviews were conducted with 29 service providers and co-ordinators from Seatown, including providers at each of the eight TW projects and other non-TW providers purposively and progressively sampled according to their relations with TW providers. This created an opportunity to test and refine emergent explanations regarding provider relations. Interview participant roles in relation to service provision are shown in Table 1. To protect anonymity, participants' specific job titles are withheld. Interview quotations are labelled by participants' general roles and pseudonyms are used where necessary.

Table 1 to be inserted here

Interviews took place over 12 months. Discussion focussed on the history of provider relations in the town, perceived balances of power between providers, processes through which providers worked together, and ways in which co-ordination between providers was perceived to influence service provision locally. In order to explore changes over time, three interviewees were interviewed twice and a second interview was arranged with providers at four out of the six TW provider organisations in the town, albeit with a different person at the organisation in some instances. Participants for these follow-up interviews were purposively sampled according to their place in the network of providers; the aim was to explore changes to the network that had been identified through observations and documentary analysis. For example, analysis indicated that the person appointed as Seatown programme manager occupied a central position within the figuration of TW providers and so this person was interviewed twice. All fieldwork was carried out by the lead author.

Interviews were audio-recorded and transcribed verbatim; the data were managed in NVivo. Coding was carried out by the primary author but on-going discussion with the

secondary authors encouraged a greater degree of detachment from the data (Perry et al., 2004, Elias, 1987). Figurational ideas were used to sensitise the researcher to particular social processes taking place at every stage of the analysis. In this respect, the use of grounded theory facilitated a "constant interplay" between generating new ideas directly from collated data and testing existing explanations of human actions as Elias (1978, 34) encouraged.

Observation and documentary data provided contextual information in which to situate interview accounts. Constant comparison of incidents across interview, observation and documentary data facilitated the synthesis of codes (Strauss and Corbin, 1998) which were used to capture the different ways in which particular ideas and issues emerged in the data (Bartlett and Payne, 1997). Following initial coding of the data, connections between codes were explored in order to develop explanations about what was taking place. The analytic concepts developed through this process formed the basis for theoretical development as Charmaz (2006) outlines.

Findings

TW projects within Seatown were commissioned by representatives from the Local Strategic Partnership (LSP) via a competitive bidding process. On the basis of 19 submitted bids, the LSP members selected eight projects to fund, delivered by six different organisations. Within these organisations, new or existing staff were appointed to deliver TW activities. In some instances, these staff had also been appointed to deliver other projects within the organisation, funded through other sources. The social dynamics between the providers that emerged as relevant within the analysis are outlined in Table 2.

Table 2 to be inserted here

Reflecting Labour policy, BIG Lottery guidance to funding applicants stipulated that programme activity should place particular emphasis on "promoting partnership working between organisations within the health sector and across other sectors to increase participation and innovation and encourage a joined up approach" to project delivery (BIG Lottery Fund, 2006, 3). A member of staff within the local primary care trust (PCT) was appointed as the TW programme manager in Seatown, to lead quarterly meetings between providers in the town and collate quarterly reports for the initiative funders. Documentary analysis and interviews revealed an expectation among TW co-ordinators that TW providers would work collaboratively with each other and with other providers in the town to refer residents to each other, to deliver joint activities and to apply for future funding together, but these expectations, particularly the first, were largely unmet. A number of concepts were developed inductively out of the data (with reference to the sensitising concepts) to explain the way in which service provider relations developed over time.

Organisational pull

The analytic concept 'organisational pull' was developed from the data and captured the way in which TW providers were interdependent with others in their organisation, which constrained their capacity to work collaboratively with TW providers at other organisations. A shared commitment to the "mission" and values of their organisation was one of the ways in which these providers were interdependent (TW provider 14). Association with a particular area of expertise shaped how providers defined their professional identities. Consequently, staff identified more closely with the specialist organisations in which they worked than with TW more generally, as these were the organisations within which their professional identities were rooted. One TW co-ordinator commented that the TW providers "see themselves as … a member of [their organisation] …as opposed to, 'I'm a member of Target Wellbeing'" (TW co-ordinator 01).

Where TW providers had experiences in common with their service users, this shaped their commitment to the client group with which the organisation worked. For example, one TW provider (TW provider 14) described how her work with young people at a mental health organisation was shaped by her own low self-esteem as a young woman. In these instances, as well as instances where providers had a long history of working with a particular client group, past experience had shaped providers' views about the priorities for services in 'deprived' areas. Providers at different organisations did not always share the same priorities. One TW provider perceived that others were "delivering their own agendas" (TW provider 12). The historically constituted social identities to which TW providers subscribed were therefore defined against other professional identities in the town. Analysis of observation and documentary data indicated that TW providers working on different projects at the same organisation worked together more frequently than did TW providers across different organisations. TW providers working on different TW projects within the same organisation reported working as "one big team" within their own organisations (TW provider 12) and, from the point of view of co-ordinators, "seem[ed] to merge together" (TW co-ordinator 01).

Organisational pull also helped to explain the way in which TW providers were drawn together because of their dependence on one another for future work. Although many TW providers were employed through short-term TW funding, there was an expectation among them that should their organisation secure funding from other sources, this might enable them to secure more paid work. TW providers were keen to ensure that collaboration facilitated their own work in a particular field; one TW provider from an organisation based some distance from the town said, "We [as an organisation] want to develop links with [the town] and develop new projects from our contacts" (TW provider 02). Providers at other organisations were sometimes

deemed by TW providers to pose a threat to the future success of their organisation. This was exacerbated by the introduction of individual project recruitment targets by TW co-ordinators, which heightened the sense of competition between TW providers. These targets (set by TW co-ordinators) were regarded by many TW providers as an important measure of success to the funders, partly because of monitoring arrangements (which were deemed to be more extensive than the delivery arrangements) and partly due to previous experiences of having funding withdrawn having failed to reach targets within past initiatives. Several TW providers expressed a fear that engaging in joint activities with other TW providers might threaten achievement of their own organisation's resident recruitment targets as the following quotation illustrates:

> I just don't think we're talking to each other as well as we could in terms of projects. And I think part of that is the fear of crossing over [project users] because we don't quite understand whether, if we have some [project users], whether another project can come in and do what they do and still count them (TW provider 02).

Several interrelated social processes developing beyond Seatown also influenced the extent to which providers were drawn towards others within their own organisation. The global economic crisis from 2007, a local government reorganisation in 2009 and a change in national government in 2010 influenced a sense of job insecurity among TW providers, which increased the importance of protecting their own organisations. Providers described the survival of their organisation as a priority in their work during this "transitional phase" (Non-TW provider 01). One non-TW provider said: "It's just a question of getting through it" (Non-TW co-ordinator 02). Therefore, the deeply-rooted behaviours of providers interwoven with the actions of others in both the TW figuration and more complex

figurations at regional, national and global levels, constrained the ways in which TW providers approached relations with providers outside of their own organisation.

Although intra-organisational interdependencies had a strong influence on providers in the early stages of the initiative, relations between providers were dynamic and over time other processes emerged that mediated the influence of these interdependencies. Analysis of observation and documentary data indicated that TW providers across different organisations shared more information about their work with one another over time. This was particularly evident at quarterly programme meetings, where TW providers shared more details about their activities over time. During one of the last quarterly meetings, providers discussed how they had felt more inclined to work with TW providers at other organisations once they had begun to achieve targets. These findings indicate that the ways in which providers are interdependent changes over time, creating opportunities for new alliances between providers.

'Local' status

The development and operationalisation of 'local' status were processes which influenced the balance of power between providers in the figuration. Being 'local' was expressed as having one or more of the following attributes: living locally, having an established history of working in the area, or working from a local office base. TW and non-TW providers and co-ordinators associated a number of positive characteristics with local status.

Local status was associated with having a good understanding of the population targeted by the initiative. This understanding was considered to be valuable by TW providers because, it was explained, it was used to inform the development of activities and recruitment methods within projects. One TW provider explained that

she had sought to appoint people who “live[d] in … local wards” to deliver TW activities because they were more likely to have local knowledge (TW provider 12). Others commented that living locally gave providers greater insight into resident needs. Local status was also associated with caring more about residents. The following quotation, from a non-TW provider at an organisation based in Seatown, demonstrates how local status was associated with an investment in its residents:

> I do what I do here and I care about it because I live here and my family lives here, I want there to be good services, you know … If I didn’t live here, would I care in the same way or would it just be about the money? (Non-TW co-ordinator 02).

Local status was explicitly defined against “outsider” status which was sometimes associated with poor understanding of residents’ needs (TW provider 03). Analysis indicated that ‘outsider’ providers were perceived as posing a threat to the position of those based in Seatown. Some ‘local’ non-TW providers, for example, expressed agitation that providers based outside of Seatown had been chosen to deliver TW projects. One out-of-town TW provider described how providers based in Seatown had predicted that his organisation would be unable to deliver the TW programme successfully:

> The initial feedback … was [that] there was no chance we would be able to do the programme [successfully] because the other people actually based in the [town and delivering similar programmes] have had no response [from residents]. (TW provider 01).

Local status was associated with legitimacy in terms of accessing Seatown resources. TW providers and co-ordinators articulated a view that being seen as local made other ‘local’ providers more inclined to refer their service users to TW. For example, TW providers whose organisation had connections with other providers in

Seatown revealed this connection to people with whom they wanted to work. One TW provider described how the "reputation" of her organisation gave it a "real advantage" when working with other providers in Seatown; she said, "they don't just want anybody coming in and working with their [users]" (TW provider 12).

Local status was cultivated by the ways in which providers worked with one another. TW providers with experience of working in the area revealed that, in some instances, they preferred to refer their service users to non-TW providers with whom they had established relationships than to other TW providers with whom they did not. Explaining why she preferred to refer her project users to one provider over another, one TW provider said:

> We've never really been able to engage with [one of the TW projects] … [another non-TW provider] will work longer with our [users] because of the working relationship we've got with them. So… there are probably other organisations that we already work with. (TW provider 14).

Referring residents to 'local' providers with whom one already had an established relationship perpetuated a provider's status as local and served to prevent other providers from accessing resources. Such was the perception that being local was an advantage that one TW provider (TW provider 05) accounted for the difficulty she had in establishing relations in the town by wrongly assuming that her organisation was the only one that was not 'local'. This indicates that local and outsider status was used effectively to exclude some providers from the provider network in the town.

Earning one's stripes

Outsider status was not fixed but, rather, was part of a fluctuating balance of power between providers. Analysis indicated that local status could be earned over time, particularly through developing relations with others who were deemed to be local. There were several processes through which the balance of power between providers shifted over time.

First, the development of “niche” activities by TW providers, which did not overlap with existing provision, facilitated the development of relations with non-TW providers (TW Provider 13). Over time, some TW providers made changes to the activities that they were delivering because they perceived that there was “overlap” with their provision and that of other TW and non-TW providers in the town (TW co-ordinator 01). Where TW providers were able to adapt what they delivered to fit with the needs of ‘local’ providers this facilitated the development of relations between them. TW providers based outside Seatown were more likely to adopt this strategy. One TW provider, for example, described how “fitting in with their agenda” made it easier to access support from local non-TW providers (TW provider 10). This can be understood with reference to the sense of competition between providers in the area. The development of a specific niche for TW activities removed some element of competition between providers and increased the likelihood that TW providers could offer something to the clients or users of non-TW services. This illustrates the way in which ‘local’ providers were able to use their status to influence what was delivered within TW, how it was delivered, and by whom.

Another way in which some TW providers became more accepted among providers in Seatown was through word-of-mouth endorsements from providers considered to be more ‘local’. TW providers at an organisation with no history of working in the town asked a TW co-ordinator, based at the PCT, to arrange meetings for them with health practitioners in the town. One co-ordinator considered that these meetings

provided legitimacy for TW providers and a “sort of reference … to actually get recognised as something that was kosher” (TW co-ordinator 01). These endorsements could start a process of discussion between providers, as one TW provider said, “It was certainly a door opener for us with the recommendation from the PCT” (TW provider 05).

TW providers considered it important that other providers understood and valued their work and this could be achieved through word-of-mouth endorsements. One TW co-ordinator said that because providers “don’t know what [a new] organisation provides, they don’t know anything about it so it takes, you know, quite a long time to … get that recognition sort of set up” (TW co-ordinator 01). Word-of-mouth endorsement from non-TW providers could therefore be effective for TW providers in developing collaborative working relationships. TW providers described how engaging one local school in a TW project could lead to the engagement of others. She said, “Generally word got around about what we could offer and other teachers would then start to ring up” (TW provider 08).

The influence of word-of-mouth processes can partly be explained by the perception among local providers that the voluntary and community sector (VCS) in Seatown was underdeveloped. With few established networks between VCS providers prior to TW, word-of-mouth endorsements helped ‘local’ VCS and statutory providers to determine whether or not it would be helpful for them to work with the newly-developed TW projects. The sense of competition between providers also influenced their sense of wariness and word-of-mouth endorsements enabled providers to judge the extent to which providers with new projects might pose a threat to their own organisations.

Discussion: Theorising Target Wellbeing

In this paper we have drawn upon key aspects of figurational sociology in order to offer a more adequate understanding of processes of joint working, which have been a key feature of social policy within many Western countries. There has been an assumption that ABI partnerships have encountered problems due to implementation failure. By emphasising the complexity of the figurations within which ABI providers were immersed, this study has shown that the problems within this ABI partnership were not chance or accidental events, nor can they be understood in terms of poor leadership; rather, they can only be understood in terms of the unplanned – and in this case unwanted – outcomes of the way in which networks of relationships between service providers developed over time.

Organisational pull was a concept developed from the data and informed by the concept of figurations to explain processes that constrained partnership development. It reflects the way in which TW providers within an organisation were drawn to work together rather than with providers outside their organisation. Elias (1978, 15) argued that individuals “are directed to and linked to each other in diverse ways through their basic dispositions and inclinations,” formed over many years through processes of socialisation or habitus formation. Working with the same people, or in a particular field of professional practice over many years, providers at the same organisation had similar priorities in terms of what they thought was needed in deprived areas such as those targeted by TW. These findings resonate with those made in the field of teacher education, where the term ‘occupational socialisation’ has been coined to explain the way in which learning processes in a particular field of occupation come to shape perceptions (Lawson, 1983). Shared dispositions could be seen to bind TW providers together in this study such that they developed a sense of allegiance to the work of their organisation. As Milbourne (2009, 291) has noted, "collaborative work often depends heavily on the commitment, dispositions and networks of individuals, and situated experiences."

Through the longitudinal approach adopted in this study we have sought to show how these commitments, dispositions and experiences of service providers are shaped through the historically constituted figurations of which they are a part.

Providers at the same organisation had a vested interest in the survival of their organisation, which became more apparent in the light of their fears about competition and funding. Competition for funding between organisations within ABIs has previously been shown to undermine capacity for collaborative working (Carlisle, 2010, Milbourne, 2009). The findings from this research extend this analysis to show that competitive processes between providers are on-going and do not necessarily recede once the commissioning process is over and that the sense of competition between providers at different organisations seemed to be exacerbated by TW monitoring and evaluation processes. One of the unintended consequences of setting resident recruitment targets at an organisational level was that TW providers were persuaded that such targets were vital to the funders, which limited TW providers' capacity to work towards other goals. Organisational pull therefore helps to explain how the interweaving actions of providers and co-ordinators led to consequences that co-ordinators, despite their apparent position of authority, could not control. The networks in which providers and co-ordinators were embedded (including those with funders and other providers) constrained the development of collaborative working.

Competition was an aspect of a struggle for power between TW providers that was predominantly shaped by the status of providers as either 'local' or 'outsiders'. Local status was used as a tool for securing resources for one's organisation. TW and non-TW providers and co-ordinators associated local status with a number of positive characteristics that facilitated collaboration with other providers. Cameron and Lloyd (2011) found that when providers understood and valued each other's work, they

were more likely to work in partnership, while Harris and Young (2010) noted that providers who have displayed a sustained commitment to a cause within a local community are likely to have gained the trust of other providers. This research extends this analysis by showing that the development of trust can create included and excluded groups within ABI partnerships. Providers often attempted to cultivate a status as 'local' in order to improve their access to resources in Seatown. This resonates with Elias and Scotson's (1965) finding that one's status as an 'established' member of a group can be used to exert considerable influence over resources that 'outsiders' might also value.

Milbourne (2009, 287) showed how competition for funding between providers can exacerbate "fear of outsider [providers]" in community-based initiatives. This research provides an explanation for Milbourne's findings by showing how the significance of outsider status in TW reflected power balances between providers. TW providers who were successfully able to claim 'local' status defined 'local' and 'outsider' status in dichotomous terms that served to reinforce their own privileged position, in much the same way identified by Elias and Scotson (1965, 81).

As noted earlier, it is important to avoid conceiving of networks of relations as static: a project like TW is more adequately conceptualised as a social process with fluctuating balances of power. As such, the position of providers as 'outsiders' could, at least to some degree, be modified. TW providers who were able to earn the endorsements of some 'local' providers and adapt their activities to fit in with them were more likely to earn local status which facilitated collaboration. These findings support the claims made by Bloyce and Murphy (2007) that 'established and outsiders' might be most helpfully used to understand degrees of establishment in a community and suggest that a provider's status in a community is in a state of flux –

shifting in response to new funding arrangements. A figurational view of power relations in constant flux seems, therefore, key to an understanding of ABI partnerships.

Conclusions

It is hoped that this study has provided a more adequate account of partnership development in ABIs than has hitherto been developed. Concepts from figurational sociology were used to inform the development of a framework that focused on the constraints on service provider and co-ordinator actions and helped to draw analytic attention to the ways in which shifting power dynamics over time shaped the way in which provider relations developed.

A number of policy and practice implications can be drawn from this work. Although previous research has revealed the potentially negative impact of competition before, it remains the case that service co-ordinators are unable to control the unplanned outcomes that often emerge from competitive processes. Although ABI co-ordinators are relatively powerful, they are still heavily dependent on those who deliver projects. Complex interdependencies are likely to limit the ability of any one group to co-ordinate service delivery even in a relatively small geographical area.

Joint working tended to be viewed as a managerial issue in this initiative, as shown by the complex monitoring arrangements that were set up. Less emphasis was placed on supporting social relations. Although monitoring processes are important, it was clear that the development of organisational targets were not conducive to collaboration between providers at different organisations. This raises questions about the ways in which joint working might be better nurtured. Co-ordinator definitions of success in this ABI were framed in terms of resident outcomes, rather than partnership development. Local status, which represented commitment to the

area and legitimacy to some providers, facilitated the development of relations between particular providers. To some extent, the concept 'being local' reflects a power struggle between providers for resources, but, given the advantages associated with local status, it might be helpful to explore how this status could be nurtured to develop more supportive conditions for collaboration.

Greater appreciation of the historically produced social networks within which providers are embedded provides a more adequate understanding of partnership working. However, these findings indicate that there is a need for more realistic expectations among policy makers about what can be achieved through short-term area-based partnerships.

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Figure1 Target Wellbeing management structure

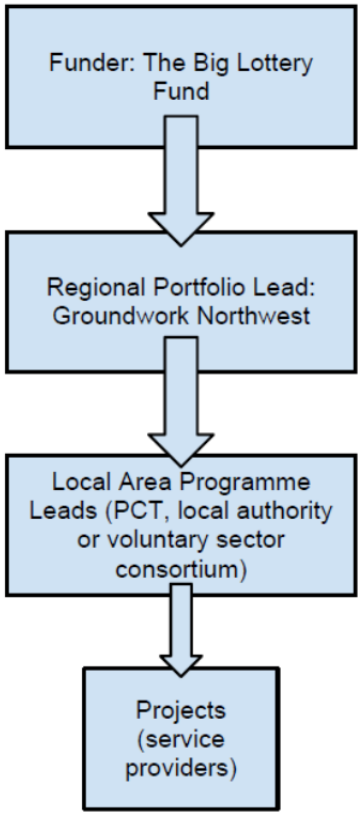

Table 1 Interview participants

Professional role of interview participant	Interview participant label	No. interviewed
Delivering TW activities within the town through face-to-face contact with residents	TW providers	15
Delivering services within the town that were not funded through TW (including healthcare providers, local authority staff and VCS staff)	Non-TW providers	4
Co-ordinating TW activities at a strategic level across the North West (VCS representatives) or within Seatown (Primary Care Trust managers)	TW co-ordinators	5
Co-ordinating and supporting service provision within the town via VCS or statutory organisations (including local authority officers)	Non-TW co-ordinators	5
Total		**29**

Table 2 Social dynamics of Target Wellbeing organisations

Sector & geographical remit	Physical location	History of service delivery in the town?	Delivered newly created or existing project(s) within TW?
County branch of a national charity	Within the town	Yes	One newly created project
Charity serving local authority area	Approximately 3 miles from the town	Yes	One existing project
County branch of a national charity	Approximately 20 miles from the town	No	Two newly created projects
Charity serving neighbouring city	Approximately 16 miles from the town	No	One existing project
Statutory-funded health centre	Within the town	Yes	Two newly created projects
Community interest company serving nearby town	Approximately 30 miles from the town	Yes	Existing project