



***Finding ways to engage with a healthy
tourism “offer”: Evaluating potential
synergies between wellbeing, public health,
and tourism at a local destination***

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A thesis submitted in partial fulfilment of the requirements of
Bournemouth University for the degree of Doctor of Philosophy

July 2017

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Abstract

This study explores and explains how the concept of wellbeing can promote synergies between public health and tourism communities of practice at a local destination level. In this context, the concept of wellbeing provides an example of a boundary object which can promote knowledge sharing across boundaries between communities of practice. Eudaimonic and integrated wellbeing theories offer alternative activity pathways to that of mass tourism and the promotion of hedonic wellbeing and may encourage collaboration between local public health and tourism departments. This study focuses on a local authority in the south of England during the transfer of many public health functions to local government. Literature acknowledges an increasing concern about wellbeing within both public health and tourism planning agendas, which considers overall societal health rooted in the wellbeing of communities. Within this context, there is an opportunity to develop a community culture that supports health creation and presents a rebranding opportunity within the destination management approach. The literature does not currently offer a theory to explain how wellbeing may contribute to a strategic alliance between public health and tourism at the local destination level.

A constructivist grounded theory approach was adopted, using methods of participant observation and interviews. Participant observation was conducted within the primary care trust, prior to the move of the public health agenda to the local authorities. Semi-structured interviews were conducted with public health and tourism team members working with the local authority. Observational and interview data was deconstructed using open coding then reconstructed into category themes and sub-themes during phases of axial and focused coding. The constant comparative approach, and theoretical sampling methods, were both used in the construction of the substantive theory.

Findings indicated that the process of change, the role of wellbeing, the context of place and engagement strategies each contribute to the development of a strategic alliance between public health and tourism communities of practice. The process of change presents a condition which may reveal opportunities for interdepartmental collaborations. Wellbeing is identified as playing a potential role in health promotion through meanings and use underpinned by community wellbeing. Place offers a context where a healthy offer can be developed for locals and tourism through greater local involvement in the planning process. Strategies to engage public health and tourism communities of practice co-locate agendas through foci on health, lifestyles and rebranding. Previous research has not connected these concepts to building a local strategic alliance between public health and tourism.

The emergent theory drawn from study findings revealed that if strategies to involve and connect residents, promote healthy lifestyles and wellbeing, and rebrand the destination

are adopted, then participants from local public health and tourism communities of practice will discover ways to engage with a healthy tourism offer. Study findings also indicate that the consequences of engaging with a healthy tourism offer include knowledge transformation, organisational efficiency and innovation, the promotion of healthy lifestyles and community wellbeing, and an alternative destination branding opportunity.

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List of Abbreviations and Acronyms

AHT	Authentic Happiness Theory
ANT	Actor Network Theory
CAQDAS	Computer Assisted Qualitative Data Analysis Software
CGT	Constructivist Grounded Theory
CoP	Community of Practice Theory
DFS	Dispositional Flow Scale
DSS	Dispositional State Scale
EWB	Eudaimonic Wellbeing
ESM	Experience Sampling Method
FSS	Flow State Scale
GRR	Greater Resistance Resources
GT	Grounded Theory
SOC	Sense of Coherence
LS	Life Satisfaction
EWB	Eudaimonic Wellbeing
HCM	Healthy Cities Movement
OHS	Orientation to Happiness Scale
PANAS	Positive and Negative Affect Scale
PERMA	Positive emotion, Engagement, Relationships, Meaning, and Accomplishment
PWB	Psychological Wellbeing
QEWB	Questionnaire for Eudaimonic Wellbeing
QoL	Quality of Life
SDT	Self Determination Theory
SPWB	Scales of Psychological Wellbeing
SWB	Subjective Wellbeing
SWLS	Satisfaction with Life Scale
WoK	Ways of Knowing Theory
WHO	World Health Organisation

Acknowledgement

To begin, this has been one of the most challenging and rewarding journeys of my life (second only to parenting). Prior to starting this PhD study I remember people talking about how profoundly the PhD journey had transformed their lives, I had no idea.....

For the opportunity to begin this transformational journey I would like to thank Bournemouth University for my studentship (and those that worked to get the project funded), it has been an immense investment in my quest for knowledge. I would also like to thank my supervisors Ann Hemingway and Susanna Curtin for their patience and support through my research journey and for sharing their experience of being successful mothers and scholars, inspiring.

Thank you to Immy Holloway for all of your support through the methodological journey, it has meant more to me than I can possibly express – you are the type of mentor that I wish I could be, one day.

Thank-you to all the study participants for sharing your thoughts, ideas and experience in this study, I could not have done it without you and am very grateful.

To my fellow thesis writers at Landsdowne campus, you have made the last stages of my PhD a thoroughly enjoyable experience, I have been incredibly fortunate to find such a positive and supportive team – my cup runneth over.

To my family, thank-you for your support across the miles. Thanks Mum for always believing.

Alison, my surrogate family member, thanks for listening to my frequent inane ramblings and helping me to stay on the right side of crazy (mostly), our shared bits of ‘nothing’, have meant everything.

I cannot go any further without taking time to acknowledge the role of my “English Family” in this journey. The Brennan family have given me more since I met them, then I can ever hope to give back, but I will forever look to find the ways. Thank-you for all for the love and kindness you have shown me, through all of the stages of this journey. To the boys Paul, Jamie, and Joel for literally putting a roof over my head and doing the little things that make life that much better. To the girls Lesley, Charlotte and Sophie for making me, once again, believe in and see the magic, in the world, every day. Lesley a massive thank-you for editing my work and being there for us, the trio.

And

Ricky and Ella-Bella you have been my inspiration each and every day.

1. INTRODUCTION

1.1 Background

Identifying the research gap

In April 2013, the UK's health agenda was reorganised with public health responsibilities shifting to local governments (Local Government Association 2017; Davies et al. 2014; Lowndes and McCaughie 2013). A focus on societal quality of life (QoL) and wellbeing are recognised by governments as central to people's lives thus, greater importance is given to enhancing local area strategy and service delivery decisions (Local Government Association 2017). An additional feature of the new public health agenda in the UK is the 'salutogenic' emphasis, which proposes that public health practice focus on aspects that both support and enhance wellbeing (Lindstrom and Ericsson 2010). Public health policy within the UK, aims to both improve societal health as well as wellbeing and quality of life within local communities (Local Government Association 2017; Anderson et al. 2010).

There have been several stages or waves in the development of public health policy, marked by shifts in thinking about the role of public health within society (Davies et al. 2014; Hanlon et al. 2011; Hemingway 2011). The current fifth wave of public health policy highlights the need for the re-evaluation of public health's role in maintaining and enhancing wellbeing. The main foci of the fifth wave of public health development are: the promotion of population level active participation and on working together to achieve health as a public good (Davies et al. 2014; Hanlon et al. 2012). An emergent conceptualisation of public health is to reject the view of ourselves as mechanics fixing what is wrong, instead understanding ourselves as gardeners enabling growth of what nourishes human life and spirit (Hemingway 2011). This is better understood as eudaimonia, which includes being true to oneself, human flourishing, striving towards personal growth, and realising one's true potential (Disabato et al. 2015; Deci and Ryan 2008).

The fifth wave of health policy development seeks a more comprehensive and sustainable understanding of wellbeing; in the quest for the meaning of life contributing to others' lives, constant learning and self-realisation, the main tenants of the eudaimonic approach to wellbeing (McMahan and Estes 2011). The fifth wave suggests that wellbeing can be achieved through greater inter-dependence and cooperation, developing the capacity to learn collaboratively (Davie et al. 2014; Hemingway 2011). The ultimate goal of contemporary public health policy is to improve and promote the health, wellbeing and QoL of a population through disease prevention, extending life expectancies, and reducing health inequalities (Hanlon et al. 2012; Munthe, 2008).

Several researchers posit that there is an increasing focus on promoting health and wellbeing which is reflected in both tourism and public health government planning agendas (Daniel et al. 2012; McCabe et al. 2010; Fayers and Machin 2007; Skevington et al. 2004). It is further contended that tourism and public planning and practice are currently moving towards a new paradigm that considers overall societal health rooted in the wellbeing of individuals and communities. (Local Government Association 2017; Anderson et al. 2010;). These trends in thinking about tourism and public health offer opportunities for synergy in local development and planning. The primary rationale for synergising tourism and public health strategies is based on the knowledge that the promotion of mental and physical health for locals and tourists is desired. Within this context, there is an opportunity to develop a community culture that supports health creation and also presents a rebranding opportunity within the destination management approach (Wall et al. 2017).

The tourism and travel industry are argued to play an important role in enhancing societal wellbeing and improving QoL and ultimately creating healthier communities (Wise and Perić 2016; Munthe 2008). The role of tourism policy is to develop a socio-economic environment enabling the sector to sustainably prosper (Stevenson et al. 2008; Ritchie and Crouch 2003), while the diversity within the tourism industry presents opportunities for synergies with public health. To date, the potential for tourism and public health to cooperate in cultivating public wellbeing has not been assessed. This study aims to critically evaluate the potential for a strategic alliance between tourism, public health and wellbeing at the destination level and hence, suggest a new direction for destination management.

Through the lens of the eudaimonic approach to wellbeing, there lies an opportunity to promote sustainable, healthy lifestyles across the UK (Wall et al. 2017). Wellbeing is currently an abstract and nebulous term that lacks either an accepted or consistent definition (Steger et al. 2006); where current conceptualisations are, uni-dimensional or multi-dimensional; subjective and objective (Cummins et al. 2003). The pairing of wellbeing (public health) and tourism as a strategic alliance presents a theoretical gap and thus, an area for research inquiry.

Currently, the direct annual healthcare costs of physical inactivity in the UK are £1.6 billion, with an additional impact on the economy of £8 billion in indirect costs (which refers to the economic value of healthy lives lost to premature mortality). In the UK, nearly half the population fail to meet physical activity targets, where physical inactivity is responsible for approximately 17% of all deaths in the UK. It is estimated that interventions targeting one fifth of Britons that are currently inactive may achieve economic benefits valuing £2.4 billion (ISCA/Cebr 2015). Visual social prompts akin to

bike hire schemes encourage greater levels of cycling and population level health benefits (Woodcock et al. 2014). Such initiatives may provide a community framework to increase activity levels and act as a 'unique selling point' (USP) for the tourist destination. A community that supports health creation presents a rebranding opportunity that interlaces health and wellbeing with marketing and economic strategies.

The UK health agenda has been reorganised and repositioned (Department of Health 2010). One of the most significant changes to the agenda is the delegation of public health responsibilities to local governments (Hartwell 2011; Local Government Improvement and Development 2010). This reorganisation supports initiatives such as UK's Healthy Cities. Healthy Cities is a global movement engaging local authorities and partner organisations in health development. The movement led and supported by the World Health Organisation (WHO), strives to build a network for European towns and cities to move health improvement to the core of local policies (UK Healthy Cities Network 2016).

1.2 Research aims and objectives

Research aim

This study will critically evaluate the potential for a strategic alliance between local public health and tourism communities of practice bridged through the boundary object of wellbeing.

Research objectives

This aim will be achieved through the following objectives:

1. To critically interrogate the literature on: wellbeing; public health; tourism; boundary objects and management.
2. To construct a substantive theory explicating the potential means to build a strategic alliance between local public health and tourism through a wellbeing construct.
3. To provide a conceptual framework of best practice for synergising public health and tourism strategies through the boundary object of wellbeing.
4. To provide appropriate recommendations for tourism and public health communities of practice within local authorities.

1.3 Structure of the thesis

This introduction chapter will provide a background to the study and a rationale for the research. Chapter two will examine the current literature related to wellbeing, public health and tourism. Chapter 3 explores the existing literature related to boundary objects

and boundary management to understand the characteristics and dimensions associated with successful boundary objects and means to effectively broker knowledge across boundaries. This initial review of the literature was conducted to better understand current theoretical breadth associated with wellbeing, public health, tourism, boundary objects, and boundary management to conceptually map potential synergies. The extensive review of literature has confirmed that there is no known existing research which has provided a theoretical explanation of how wellbeing, public health and tourism can be synergised at a local destination. This study will address this gap.

Chapter four outlines the philosophical and methodological approach used within this study to demonstrate how the research inquiry is embedded within the knowledge framework and the methodological approach is the best fit for collecting rich data. The study uses a qualitative, constructivist grounded theory methodological approach. This allows an explanatory theory to be constructed which is grounded within collected data which is set within a particular time, place and culture.

Chapter five outlines the methods used within the constructivist grounded theory approach. The use of the literature is outlined and methods of data collection and analysis are detailed. Participant observation was used to collect data about the public health community of practice at the primary care trust prior to their move to the local authority in April 2013. Interviews were used to collect data from a purposively selected sample of individuals working with public health and tourism teams at the local authority, approximately six months after the shift of the public health agenda to the local authority.

The combined study findings and discussion are presented in chapters six, seven, eight, nine and ten. These chapters outline how individuals find ways to engage with a healthy tourism offer, during and after the shift of the public health agenda and responsibilities to the local authority. They additionally provide evidence about the factors that are involved in the adoption of the phenomenon of finding ways to engage with a healthy tourism offer. The findings and discussion are presented together to avoid fragmentation and repetition, with the goal of providing a clear, cohesive narrative.

Chapter six presents the findings and discussion related to the process of change, which includes an evaluation of theory and literature. The process of change is identified as a causal condition in relation to the study's phenomenon. Organisational change theories are compared to study findings, where it is suggested that findings challenge elements of existing theories.

Chapter seven offers the findings and discussion related to the role of wellbeing. In the context of the study, wellbeing is recognised as an intervening condition in relation the phenomenon. Wellbeing theories are evaluated up to the study findings and it is

proposed that theories integrating hedonic and eudaimonic elements may increase the potential for the development of a strategic alliance.

Chapter eight outlines the findings and discussion associated with the context of place, in this case, a coastal destination. Theories about place relations are compared to experiences' of locals and tourists, with current gaps in theory being identified.

Chapter nine outlines the findings and discussion relating the engagement strategies that could synergise wellbeing, public health and tourism. Potential strategies to cross boundaries across local communities of practice are suggested. The benefits associated with crossing boundaries and managing boundary knowledge is also identified.

Chapter ten presents the findings and discussions related to the study's central phenomenon of finding ways to engage with a healthy tourism offer. Relationships are mapped between the four other emergent categories in the study: the process of change, the role of wellbeing, the context of place and engagement strategies.

Chapter eleven discusses study implications, reflections and conclusions. The theory developed from the study findings is described. Implications for practice, policy and future research are outlined. The contribution of this study to knowledge is presented. The outline of the thesis structure is depicted in Figure 1.

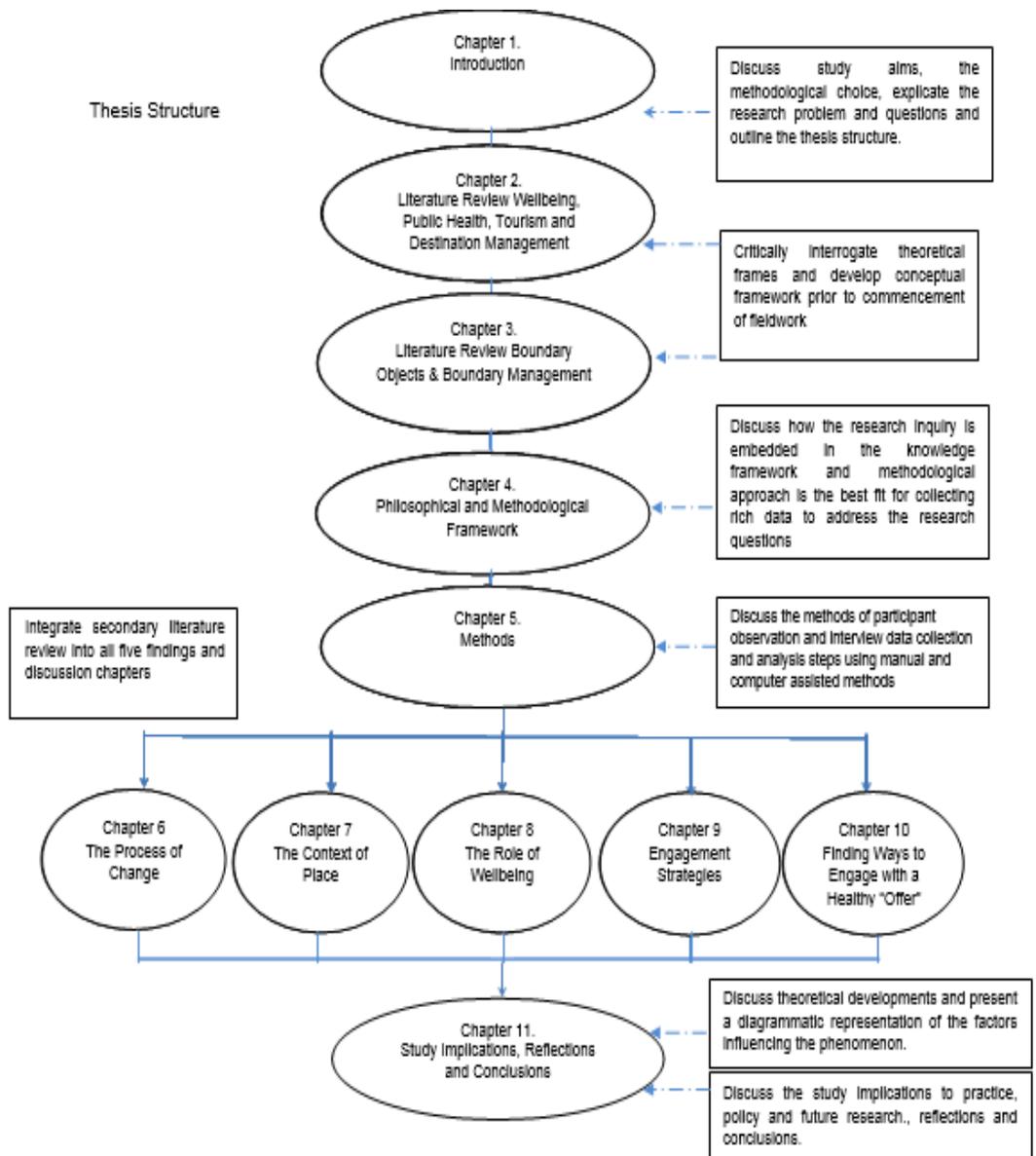


Figure 1: Outline of the thesis structure

1.4 Scene-setting for the study

Context

The study focuses on a town in the south of England, a popular coastal destination for UK tourists that has historically been connected to health, wellbeing and tourism (Walton 2000, 1981). The population in the area has historically been comprised of a mix of retired individuals, a seasonal population of holiday-makers, and those employed to support the tourism destination (Gilbert 1939). The development of this seaside resort has been primarily connected to members of the medical profession in the mid-eighteenth century advising their patients to visit the seaside, in order to improve their health (Gilbert 1939).

As a destination, the town aims to attract visitors to the area with their seven miles of award-winning beaches (Brett 2016). While in recent times known as both a retirement hub and popular location for hen and stag party nights' out, the area has more recently been recognised for undergoing a transformation (Brett 2016; Glaister 2015; Haddad 2014). The town has been increasingly lauded for its regeneration efforts and modernisation with evidence that the town as a destination is in the process of changing (Glaister 2015). Recently, the destination's popularity has increased by 353% on Airbnb, and was listed as second most trending destination in the world, second only to Gangneung, Korea (Airbnb Travel Trends Report 2018). Alongside the rising popularity of the destination, the health and wellbeing sector is experiencing unprecedented growth and is currently seeing continued development each year (Hindley 2018). This growth in the health and wellbeing sector demands short and long-term planning to consider the diversification of the tourism market within this seaside town, considering the town's current and future tourism offer.

Domestic tourism & potential growth areas

Domestic tourism within the UK, has been valued at eight billion GBP for overnight and day trip expenditures, this study focuses on a coastal destination, which accounts for over 35% of the annual overnight spend (GBTS 2015; GBDVS 2015). Recent place-based studies have recognised key opportunities for growth within this coastal town, specifically highlighting areas of health and wellness (NCTA 2016). It is further suggested that wellness holidays are increasingly popular, with one in five Britons currently taking a wellness break, which has further risen to a third amongst the 18-34 year old demographic. Additionally, wellness holiday locations are identified to be coastal by 48% of Britons (BDRS Continental 2016). Factors including pace of life, employees stress levels, and the subsequent need to simplify, slow down and find meaning in life has led to the intense growth of wellbeing tourism which is part of the wellness industry (Smith

and Puczkó 2008; Douglas 2001; Pollock and Williams 2000). As a global industry, wellbeing tourism is acknowledged as a rapidly expanding industry that aims to promote health (Rodrigues et al. 2010; Kelly 2010). This outward concern for health within the town may be timely as there are escalating health challenges acknowledged across the local population. As well, there may be an opportunity for the town to increase its market share of the flourishing health and wellness industry.

Identified local health challenges

Situating the study within current identified challenges to the delivery of health services, public health have outlined that there is an inability to keep pace with growing demands and costs associated with ill health, with an estimated £229 million a year shortfall (Sustainability and Transformation Plan 2016). Contributing factors include a projected population increase in the area, the majority of whom are older people. Lifestyle factors also contribute to decreasing levels of wellbeing and ill health, where obesity, alcohol consumption, smoking and inactivity are largely contributing to these financial gaps. In this vein current trends predict that obesity will become a more extensive challenge by 2020, where approximately 1 in 10 members of the local population may suffer from diabetes and 1 in 8 may be diagnosed with heart disease (Sustainability and Transformation Plan 2016). These recognised challenges to health highlight the need for innovative approaches to improve local levels of health and wellbeing.

Tourism foci: competitive advantage, innovation, and ongoing rebranding

A primary task of a local authority is to develop and redevelop a successful brand for their town (Lucarelli and Berg 2011). This branding process includes interventions which focus on the promotion and marketing of place (Giovanardi et al. 2013). The dynamic nature of tourism can be conceptualised in the Tourism Area Life Cycle (TALC) (Butler 1980) which underlines the forces that can promote the evolution of a tourism destination over time (UN-ECLAC 2008). In this vein, it is further proposed that that there are factors related to the TALC that are connected to competitiveness and need to be addressed through tourism planning and strategy (ECLAC 2008). In the context of a town that is recognised as a tourism destination, there is an ongoing need to consider competitiveness and successfully capture market trends. In addition, scholars suggest that there is a need for destinations to develop an identity that is unique – in order to distinguish themselves from their competitors (Morgan et al. 2004). In addition to the ongoing challenge to keep destination branding current, there is also the additional pressure for local authorities to identify greater efficiencies in the wake of austerity

Local government reform and need for efficiencies

Faced with the current health crisis, local governments are grappling with how they are going to cope. Within this current climate, the importance of knowledge sharing and knowledge transfer offer a potential strategy to improve the organisation's performance (Epple et al. 1996; Galbraith 1990). Within this context, there is a demand to determine more efficient and informed means of working across organisational boundaries, Scholars suggest that there is an increasing need for boundary crossing within our knowledge society which is dependent upon interdisciplinary working (Fox; Meyers 2010; Rotmans et al. 2003). Additionally boundary objects have been associated with: enhanced decision-making (Spee and Jarzabkowski 2009); understanding (Williams and Wake 2007); and building strategic outcomes (Fox 2011). There is not currently a theory that connects how wellbeing as a boundary object could contribute to the development of a strategic alliance between intra-organisational departments within local government.

Potential advantages associated with public health and tourism collaboration

Knowledge sharing and competitive advantage

Past research connects a region's competitive advantage with an actor's and group's ability to convert knowledge creation into strategic action (Henriksen and Halkier 2009; Castells 2005). In this vein, scholars also acknowledge that employees' tacit knowledge and the corporate culture are inextricably linked (Teece 1998; Nahapiet and Ghoshal 1998). In this context, knowledge is recognised as the most significant resource within an organisation (Nahapiet and Ghoshal 1998; Spencer and Grant 1996). Within the local authority of focus in this study, there is the potential for a strategic collaboration to enhance the tourism offer within strategies akin to the 'Seafront Strategy' where the public health team may illuminate factors that could contribute to local resident's health and wellbeing which may then provide additional wellbeing activity pathways for tourists. In turn, this more strategic plan may ultimately contribute to the development of a more comprehensive destination brand and arguably, their competitive advantage.

Problem solving – healthcare crisis

Collaboration refers to a deliberate relationship which is intended to solve an organisational problem within a set of identified limitations (Agranoff and McGuire). These limitations may include time, money, knowledge and competition (Schrage 1995). In the case of the local authority, there are increasing financial pressures for greater efficiencies largely based on the current health crisis. Current figures estimate that the current annual healthcare costs of physical inactivity are £1.6 billion (ISCA/CEBR 2015). The development of collaborative initiatives may contribute to the development of a community framework, akin to the Healthy Cities initiative, to increase activity levels and

further enhance the appeal of the destination brand which promote health and wellbeing (De Leeuw and Simos 2017).

Wellbeing meanings & use

Scholars acknowledge that wellbeing lacks an accepted or consistent definition (Steger et al. 2006). In addition, eudaimonic and hedonic wellbeing approaches to activities may ultimately contribute to greater levels of wellbeing for tourists and residents alike (Huta and Ryan). Thus a strategic alliance between public health and tourism may be an avenue to explore types of activity pathways which may lead to healthier communities and diverse tourism offerings. Additionally, the development of a local strategic alliance between public health and tourism may further contribute to understandings about definitional use of wellbeing towards best practice. Whilst there are several acknowledge advantages of building a strategic alliance between local public health and tourism departments through the concept of wellbeing, there are potential barriers to developing this collaboration that can be conceptualised as being either individual or organisational (Riege 2005).

Potential barriers to public health and tourism collaboration

Individual barriers

There have been several potential barriers acknowledged to knowledge-sharing or collaboration (Riege 2005; Meyer 2002; O'Dell and Grayson 1998; Nonaka and Takeuchi 1995). As a starting point, scholars outline the challenges associated with knowledge sharing between individuals with differing perspectives, backgrounds and motivations which can create knowledge silos (Nonaka and Takeuchi 1995). Barriers to knowledge-sharing or collaboration are also attributed to: deficient communications skills and social networks, and insufficient time and trust (Riege 2005; Meyer 2002; Hendriks 1999). In terms of acknowledged time constraints, managers despite their awareness of the advantages associated with knowledge sharing, fail to implement these strategies due to a lack of time (O'Dell and Grayson 1998). Additionally, there is a proposed connection between perceived job-security and a resistance to share knowledge, where employees may be uncertain about the sharing objectives set out by management (Lelic 2001).

Organisational barriers

A barrier to knowledge sharing that is not often considered relates to the spatial layout for work teams which may not encourage knowledge-sharing and collaborative activities (Riege 2005). Past studies suggest that traditional spatial arrangements are based on hierarchies rather than promoting the exchange of knowledge (Probst et al. 2000). This is recognised to be an obstacle as face-to-face contact helps to develop trust-based relationships (Riege 2005). An organisation's structure may also be a barrier to

knowledge sharing in the case of highly structured, hierarchical organisations with a top-down communication flow, as knowledge sharing is more likely within flat organisations (Ives et al. 2000; O'Dell and Grayson 1998).

In addition to spatial and structural considerations, knowledge sharing barriers have also been connected to organisational culture and intra-organisational cultural differences (McDermott and O'Dell 2001; De Long and Fahey 2000). Lastly, Riege (2005) acknowledges that there is no direct ownership over employees' knowledge and it can be lost when the employee leaves an organisation. Thus, a barrier to knowledge sharing and organisational learning is connected to the retention of highly skilled employees in an increasingly mobile marketplace. While acknowledging these notable barriers to collaboration between public health and tourism departments, an analysis of related contexts reveals the potential entry points for collaboration between these two local departments.

Potential entry points for collaborative working

The fact that local government currently has the responsibility for healthcare as outlined within the coalition government's 2010 white paper *Equity and excellence: liberating the NHS* (Lang and Rayner; McKee et al 2011; Walsh 2010). The collective responsibility of the council for the health of their residents presents a necessary engagement point for all members of council. Since the move of the public health responsibilities to the local authority in April 2013, new forums have been set-up to facilitate intra-organisational collaboration across council departments. For example, the public health development forum was established with a mandate to map the links between public health outcomes and public health issues across the existing service directorates and plans. In addition, the phased development of the seafront strategy presents an opportunity to develop a healthy seaside strategy which could in turn produce a more diverse tourism offer which could benefit both tourists and residents.

The local seafront is used by both residents and tourists, for example, in the height of the summer, peak season, over 60% of those surveyed on the seafront were residents (Seafront Survey 2014). Kanika and colleagues (2006) propose that the place relations of the residents and their needs are important to destination development, as are the place relations of the tourists. Thus, creating opportunities for residents to be involved within tourism planning processes could twofold sharpen the local tourism offer and bridge any existing tensions between residents and the destination's development.

Change within local governments has been noted to be an ongoing challenge, within public health alone reorganisation has been frequent, with no less than fifteen identifiable major structural changes in the last three decades, which is approximately one every

couple of years (Walshe 2010). Past literature suggests that change is enabled through creativity, innovation, and initiative where creativity is connected with idea generation, innovation and implementation (Rank et al. 2004). Within this context, innovation necessitates transformation of work roles as well as the implementation of new ideas within work teams (Wes and Anderson 1996). The ongoing reality of change within the context of local government presents an opportunity for intra-organisational collaborations to develop creative solutions.

Relatedly, another example of a potential entry point would be with the organisation's knowledge brokers at varying levels within the organisation. This practice of brokering has been defined by Wenger (1998) as that which involves the processes of translation, coordination, and alignment between viewpoints and involves connecting practices through the facilitation of transactions. Sverrison (2001) contends that these activities necessitate various tools like organising meetings or forums, developing databases, and creating plain language guides (Kramer and Wells 2005). These knowledge brokering activities may be further enhanced through the use of boundary objects, which have been noted to potentially improve the capability of an idea theory or practice (Wenger 1998; Brown and Duguid 1991). Within the context of this study, the concept of wellbeing is identified as a potential boundary object which offers a starting point for a conversation between health and tourism sectors within the local government.

Better understanding about the meanings and definitions that are associated with wellbeing within a local context across different departments in local council and the related implications, offer a potential point of intersection. Exploring whether wellbeing is framed as eudaimonic within each of the departments, a term which denotes psychological wellbeing, virtue/excellence, intrinsic motivation/authenticity, flow, fully functioning, meaning and purpose, and a concern for others (Wong 2011). The overlap in meanings and understanding around the concept of wellbeing could lead to the collaborative development of interventions between departments. Eudaimonic living and pursuits have been associated with more prosocial behaviour (Waterman 1981), further benefiting the collective at family and societal levels (Ryan et al. 2006). Additionally eudaimonic pursuits have been connected to a higher baseline of wellbeing and more lasting subjective wellbeing, as well and with greater levels of physical health (Ryff and Singer 2006; Williams et al. 1998).

For example, members from both the public health and tourism teams recognised the importance of social connection as connected to achieving greater levels of wellbeing. Past literature also indicates that there is a link between social connectedness and greater levels of wellbeing (Jose et al. 2012; Lee and Robbins 1995). The current case study has recognised the challenge of loneliness and depression, which further

challenge levels of wellbeing, the quality and quantity of life. Thus, programmes developed between public health and tourism departments may provide the opportunity to build interventions which are focused on promoting greater social connections. Health promotion programmes could increase strategies to engage members of the community that are at risk of suffering from loneliness and be included within the seafront strategy.

An example, would be the recent development of the annual marathon festival which is defined as a serious leisure activity, one that requires special skills and knowledge and may not be entirely pleasurable at times (Stebbins 2008, 1997). There are a host of personal rewards that are associated with serious leisure and include fulfilling one's human potential, having cherished experiences and developing a valued identity (Stebbins 2001). Participation within this type of event has been identified by participants to be both satisfying and rewarding (Stebbins 1997) and can also be theoretically aligned with eudaimonia (Voight et al. 2010). Figure 2, outlines the potential barriers and entry points to collaborative working between public health and tourism departments. Barriers to collaboration are identified within the red arrows and the green arrows outline the potential entry points for intra-organisational collaboration. The figure also outlines the main areas of focus for public health and tourism departments within the local authority. The mapping of the potential factors influencing synergies between sectors with the local authority provides a conceptualisation of areas which may contribute to collaborative working bridged through the concept of wellbeing.

1.5 Past 'Well-being tourism' case studies

Recently, there has been the emergence of case studies evaluating aspects associated with wellbeing tourism at a destination level (Medina-Muñoz and Medina-Muñoz 2013; Huijebens 2011; Maneenet et al. 2014)). This section will evaluate three case studies Gran Canaria, Spain; cluster, Thailand; and Mývatn Nature Baths, Iceland in terms of the associated opportunities and challenges, and how they inform and situate the current study.

Gran Canaria

Medina-Muñoz and Medina-Muñoz (2013) analyse the case study of wellbeing tourism in Gran Canaria, Spain, focusing on diversifying the coastal tourism offer. In this context, Gran Canaria is recognised as a mass coastal destination which is suggested to have a need to consider options to adapt and evolve to reflect current and future tourism trends. This case study provides a useful example of a coastal destination that has embedded wellness tourism within their corporate strategy (Canarian Government Department of Tourism 2009). The starting point for their evaluation is from the perspective of the commodification of therapeutic landscape, proposing that wellness tourism is a highly

desirable tourism product. The main contributions of this case study are the connections made between socio-economic characteristics with travel motivations and wellness behaviours.

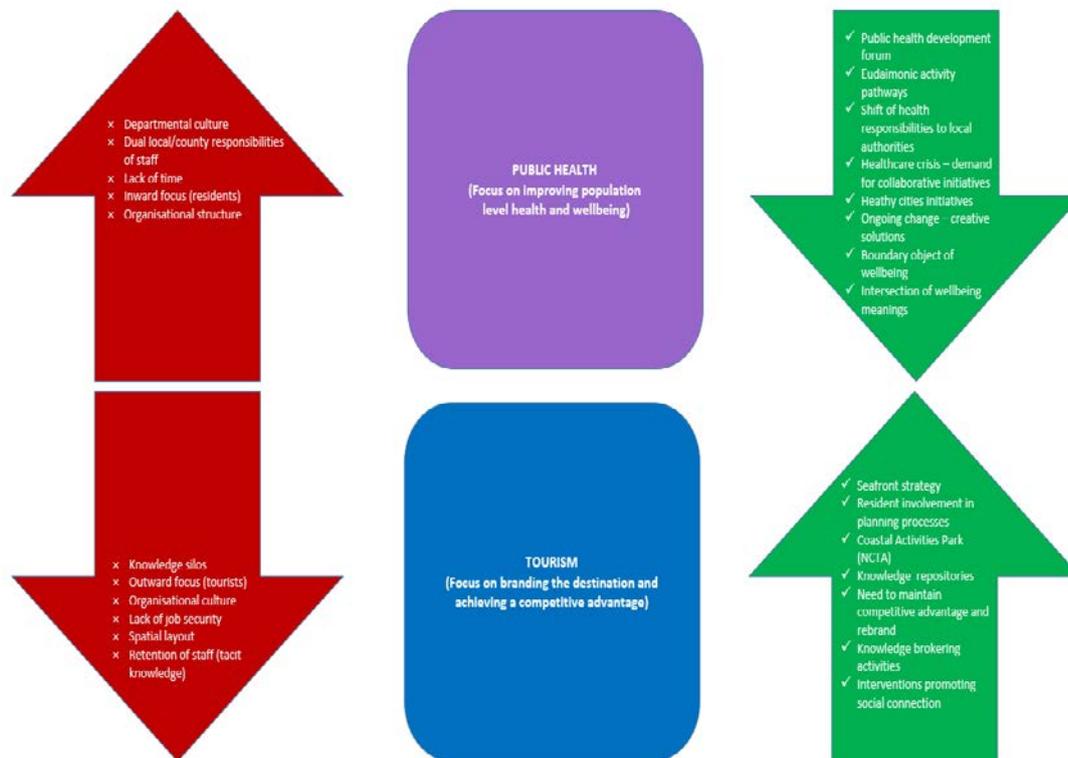


Figure 2: Potential factors influencing synergies between public health and tourism sectors

This case study provides a synthesis of the debates in tourist motivations and behaviour, as related to the pursuit of health. Additionally, it provides a useful contextual background regarding the demand for wellness tourism in the analysis of recent case studies which focus on wellbeing tourism. The demand for wellbeing or wellness tourism both at destinations and within the current body of literature provides an indication of the significance of the timing for this research evaluating the means to develop a healthy tourism offer at a UK coastal destination. This case study also, provide an example of a destination, which is showing signs of decline, has implemented a tourism diversification strategy to position and market wellness tourism. Findings indicate that wellness behaviours at the destination are influenced by socio-economic characteristics, in turn these findings may influence collaborative efforts within local government (in this current study) to best market wellness tourism and plan wellbeing activity pathways. The case study provides recommendations for future research which includes a need for more

research focused on wellness experiences which combine the business offer (O'Dell 2010; Vespestad and Lindberg 2011).

Roi-Kaen-San-Sin cluster, Thailand

In this case study, Maneenetr and colleagues (2014) focus on the investigation of tourists' opinions about wellness tourism in the Roi-Kaen-San-Sin (RKSS) cluster in Thailand. Within this context, Thai meditation practice or retreat minds are associated with wellness tourism. The main aims of the research are to determine tourists' views of wellbeing tourism in the SKSS cluster and further investigate the recommendations for best practice in developing wellbeing tourism. The main findings indicate that the following priority areas in developing wellbeing tourism within the RKSS cluster: improving the quality of infrastructure; development of website to promote wellness tourism; creating a map which highlights popular wellness destinations; and diversifying wellness activities to embrace culture.

The Roi-Kaen-San-Sin cluster case study further highlighted the growth of wellness tourism within Thailand and its potential to rejuvenate stagnant areas. The research was also framed based on the assumption that successful tourism destination development is premised upon enhancing the wellbeing of its residents. In applying these research threads to the current study, the growth of wellbeing tourism provides further impetus for evaluating the potential synergies between the local tourism department, outward tourist focus, and the public health department, inward resident focus, as bridged through the concept of wellbeing. Additionally, the consideration of resident wellbeing in destination development provides further justification for the current study which focuses on the dual interest in tourist and resident wellbeing.

Mývatn Nature Baths, Iceland

Huijbens, E. H. (2011). Developing wellness in Iceland. Theming wellness destinations the Nordic way. *Scandinavian journal of hospitality and tourism*, 11:1. 20-41.

The frame for this case study is to emphasise the importance of wellness and wellbeing tourism in the planning and development of the Nordic tourism product. In this case study, Huijbens (2011), focuses on the Mývatn region in North East Iceland, more specifically the Mývatn Nature Baths (MNB), and focuses on the context and related outcomes of developing a wellness/wellbeing destination. More specifically, the case study evaluated the Nordic wellbeing concept, specific to the destination. The case study is built upon the assumption that wellness and wellbeing are identified as concrete products in the development of Nordic tourism. Within the context of this article, it is proposed that wellness can be seen as aspirational, which can be obtained through

purchase. Thus, from this perspective, wellbeing tourism becomes a part of consumptive practice.

The researcher conducted interviews with members from both the Ministry of Health and the Ministry of Tourism, and focused on participants' perceptions of the unique selling points associated with the specific Nordic destination, Mývatn Nature Baths. Additionally, participants were questioned about the connections between their understandings of health and wellbeing and innovation in their work activities.

One of the main findings drawn from this research is that there was a notable lack of integration in the vision and development of the wellness destinations, which underlines the importance of collaborative planning in tourism destination development. In terms of the MNB, there is a resource, but there is not currently any integration of the terms wellbeing or wellness within tourism product development. Currently, wellbeing tourism is in its infancy, currently lacking a regionally integrated vision or strategy. One challenge identified is the uneasy relationship between tourism entrepreneurs and medical professionals which is suggested to arise from tourism's unwillingness to invest in research to better focus marketing efforts. Confirms past research that there is a lack of interest and skills in tourism towards the development of wellness products.

Conclusions drawn from this study include that the Nordic wellbeing concept is currently vague. Business entrepreneurs within this area, gained insight from the management practices in other Nordic countries. The main unique selling proposition identified within the study is Iceland's hot water and the juxtaposition of hot and cold which could ultimately cleanse both body and spirit.

Summary

Each of these case studies highlight both the potential advantages and challenges that are associated with the development of wellness or wellbeing tourism at the destination level. All case studies reviewed, provide further evidence of the growing demand for wellbeing tourism and its potential to rejuvenate mature/stagnant tourism economies. In the case of Gran Canaria, Medina-Muñoz and Medina-Muñoz (2013) provide an example of a tourism diversification strategy to draw upon. Findings additionally indicate the role of socio-economic influences which may have help to catalyse collaborative interventions within the current study. The case study focusing of the Roi-Kaen-San-Sin cluster in northern Thailand connects tourists' perceptions of wellbeing tourism and recommendation for wellbeing tourism development. In this case study Maneenet and colleagues (2014), highlight the importance of considering resident wellbeing in the development of the wellbeing tourism offer. In addition, findings reveal the importance of

considering: infrastructure, marketing material i.e. a website, collective regional promotion, and considering culture when developing wellness activities.

The final case study reviewed, the Mývatn Nature Baths in Iceland where Huijbens (2011) evaluated the Nordic wellbeing concept as represented at the specific destination. This case study is based on the assumption that wellbeing tourism is a product and is part of consumptive practice. Findings highlight the often uneasy relationship between tourism and medical professionals and the resistance of the former to develop wellness products. These case studies collectively illustrate some of the advantages and challenges associated with developing wellbeing tourism at the destination level, these studies provide both justification for the current study and sensitizing concepts to be aware of in the analysis of data and synthesis of findings. The next chapter provides a review of wellbeing, public health and tourism management literature which aim to both situate and inform the current study.

2. LITERATURE REVIEW: WELLBEING, PUBLIC HEALTH & TOURISM

2.1 Introduction

This chapter begins by presenting a critical interrogation of the literature on wellbeing, public health, tourism and destination management, which aims to co-locate local public health and tourism within the construct of wellbeing. This will be accomplished through the outline of current debates within wellbeing literature around definition, use, theory and philosophical influences. Next, the context of public health will be assessed in terms of the current drivers and theoretical influences (salutogenic). Finally, the evaluation of tourism and destination management literature will evaluate theoretical roots and the potential 'fit' within theoretical conceptualisations of wellbeing. The chapter will highlight the potential theoretical underpinnings, which may synergise local tourism and public health and further provide destination rebranding opportunities.

2.2 Wellbeing

Wellbeing as a construct, presents challenges to both researchers and practitioners (Dodge et al. 2012; Forgeard et al. 2011), as it has numerous definitions, related theories and dimensions (Fleuret and Atkinson 2007). This section will outline debates within the literature about wellbeing definition, historical context and impact, and theoretical underpinnings and related measurements. Additionally, the literature review will seek to provide a clearer conceptual understanding of the terms wellness, quality of life, life satisfaction and happiness. This systematic analysis serves to map the theoretical domains of wellbeing in hedonic and eudaimonic contexts and set a frame for understanding how wellbeing may synergise public health and tourism communities of practice.

Defining wellbeing

In the last decades, there has been a proliferation of wellbeing research (Atkinson et al. 2012; Seligman 2011; Keyes et al. 2002; Diener et al. 1999), yet the debate about how it should be defined remains unresolved (Disabato et al. 2015; Dodge et al. 2012) further giving rise to the development and use of broad and blurry definitions (Foregard et al. 2011). As it stands, wellbeing is defined as both a complex and multi-faceted construct that has eluded attempts at definition and measurement (Pollard and Lee 2003). Research suggests that one of the main challenges lies in the fact that there has been a preoccupation in wellbeing research with the dimensions versus the definition of wellbeing (Christopher 1999). Thomas (2009) contends that it is a concept which is challenging, intangible, hard to define and ever more difficult to measure. Furthermore,

it is recommended that any definition of wellbeing needs to go past a mere account or description of wellbeing, and clearly state the meaning of the term (Dodge et al. 2012). Conversely, other researchers, amidst the mire of definitions, contend that wellbeing is most useful as an umbrella concept (Sirgy 2012; Gasper 2007; Diener 2006; Gough 2005).

Several studies recognise the absence of theoretical explanations of wellbeing (Ryff and Keyes 1995). Likewise, there are many researchers that underline the lack of a clear wellbeing conceptual framework (Fleuret and Atkinson 2007) and that there is a need for a more systematic approach (Diener and Seligman 2004). Despite these numerous critiques, there have been attempts to define wellbeing in terms of its theoretical underpinnings (Cummins 2010; Headey and Wearing 1989).

More recently, Dodge et al. (2012) propose a definition of wellbeing, depicted in Figure 3.



Figure 3: Visual representation of wellbeing definition (Dodge et al. 2012).

This wellbeing definition reflects the synthesis of a systematic theoretical review, focusing on the three key areas of: a set point for wellbeing, the predictability of equilibrium/homeostasis, and the shifting state between challenges and resources. As illustrated within Figure 2, the see-saw symbol represents an individual's drive to return to a wellbeing set-point (Headey and Wearing 1989) or their need for equilibrium or homeostasis (Cummins 2010). Within this depiction, resources and challenges can affect an individual's equilibrium, akin to the concept of 'flow' (Csikszentmihalyi 2002). This definitional understanding of wellbeing challenges Cummins and colleagues' (2002) notion of subjective wellbeing (SWB) being static when the individual is not challenged, rather contending that a lack of challenge will lead to stagnation (Hendry and Kloep 2002) and imbalance. This definitional proposition is highlighted, as it presents a means to understand wellbeing within the context of this study's aims and objectives.

Additionally, literature reviewed indicates that wellbeing scholars have emphasised different components: goal fulfillment (Foresight Mental Capital and Wellbeing Project

2008); happiness (Pollard and Lee 2003); and life satisfaction (Diener and Suh 1997). Despite the potential differences in approach, the majority of researchers contend that wellbeing is a multidimensional construct (Michaelson et al. 2009; Stiglitz et al. 2009) which has ultimately led to the creation of a muddled and contrary research base (Pollard and Lee 2003). Another challenge of the multifaceted nature of wellbeing is the research tendency to ignore this range and diversity, rather focusing on one construct, thus ignoring many significant aspects of wellbeing (Forgeard et al. 2011).

2.3 Wellness, quality of life, life satisfaction, and happiness

While there is confusion amongst researchers about the definition of wellbeing, this is further confounded by the misuse and often interchangeable use of the terms wellness, quality of life, life satisfaction and happiness (Filep and Deery 2010). The concepts of wellbeing, wellness, quality of life, life satisfaction and happiness have been examined from a number of perspectives including individuals and communities (Kirsten et al. 2009), international development (Przeworski et al. 2000), economics (Gruen and Klasen 2012), politics (O'Neil 1993), and health care and health psychology (Camfield and Skevington 2008). There remains no agreement within the literature, however, about how these concepts interrelate (Camfield and Skevington 2008), which is often due to the complexity and diversity in the definitions used (Andereck and Nyaupane 2012). As a result, research contends that the concepts are often used simultaneously or interchangeably (McCabe et al 2010; Conceição and Bandura 2008). Additionally, some studies contend that overall happiness is the same as life satisfaction and subjective wellbeing (Veenhoven 1984).

Wellness

To further confuse researchers, the term wellness is often used synonymously with wellbeing (Huebner et al. 1999; Ryff and Keyes 1995). While wellness has also been used as a broader umbrella term (Nawijn 2010), many studies consider it to be situated in contrast to illness (Kirsten et al. 2009). In this vein, some studies identify wellness as being central to counselling and development (Myers 1992). Despite the growing attention to the concept of wellness within extant literature, there is a lack of agreement about its definition (Roscoe 2009). The concept of wellness is associated with Halbert Dunn (1959) who combined the words wellbeing and fitness. Dunn introduced his model of high-level wellness, which comprised of the balance of mind, body and spirit within the social environment (Konu et al. 2010; Mueller and Kaufmann 2001). For clarity, the term wellbeing will be used solely within the context of this study.

Quality of life (QoL)

Researchers contend that a notable challenge with the term quality of life (QoL), is in its interchangeable use with the concept of wellbeing, within a range of disciplines (Dodge et al. 2012; Camfield and Skevington 2008; Sirgy 2002). Moreover, there is a recognised gap in the proliferation of quality of life measures and agreement about what it actually is (Bloodworth 2005). Andereck and Nyupane (2011) acknowledge that there are currently more than a hundred definitions of quality of life. Quality of life is proposed to measure how an individual's present life corresponds with their hopes and expectations (Cummins et al. 2003). The majority of scholars would agree that wellbeing is an aspect of QoL (Sirgy 1998) that can be categorised as either objective or subjective (Cummins et al. 2003).

QoL definitions have been predominantly objective, measuring functional status, more recently however, subjective definitions have replaced them (Camfield and Skevington 2008). For example, the World Health Organisation conceptualised QoL in cross cultural terms, where it was defined in terms of an individual's perception of their place in life within the context of the operating culture and value systems as connected to their goals and expectations (Skevington et al. 2004; WHOQOL Group 1994).

One of the main critiques of this definition of QoL is in its remarkable resemblance to subjective wellbeing (SWB) definitions, leading researchers to question whether this new definition has made SWB redundant (Camfield and Skevington 2008), and for future studies to recommend greater empirical evidence to answer these levels of inquiry (Foregeard et al. 2011). Additionally, there is an acknowledged challenge in that differing research communities seem unaware of one another's work, for example, the lack of integration of Diener and Suh's (1997) international work on SWB into research on health-related quality of life (HRQOL) (Camfield and Skevington 2008). Additionally, the measures of QoL have been criticised based on their self-report nature which is influenced by: orientation (Schkade and Kahneman 1998); mood (Diener et al. 1999); and timing (Redelmeier and Kahneman 1996). Research acknowledges that there is still a gap in current understanding about processes as they relate to QoL domains (Camfield and Skevington 2008).

Life satisfaction

Life satisfaction has also been linked to the concept of wellbeing (Wu 2009) and can be measured in terms of happiness (Australian Unity 2010). Much research supports the notion that psycho-social wellbeing ought to be measured psychometrically in terms of an individual's life satisfaction and happiness (Le Masurier et al. 2010; Galloway et al. 2006; Haggerty et al. 2001).

Life satisfaction, while seen as a significant concept, is recognised by many researchers, as being part of SWB and therefore secondary to it (Diener 2006). Researchers still seem unclear about the relationship of LS to QoL (Camfield and Skevington 2008). Additionally, there are some researchers who claim that LS is a social indicator of QoL and is a means for it to be operationalised (Diener et al. 1999).

Happiness

Happiness has often been defined as positive affect (Layard 2005) yet, it has also been associated with referring to a predominantly positive mood (Diener 2006). Research indicates that the concept of happiness is often viewed as being synonymous with SWB (Ratzlaff et al. 2000) and within the UK is also used interchangeably with QoL (Skevington et al. 1997).

In terms of happiness as a construct, researchers view it to be awkward (Seligman 2011) thus, expending much effort deconstructing happiness into more basic, measurement items (Forgeard et al. 2011). For example, within psychology, happiness has often been accepted as the sum of all pleasures and pains and the overall appreciation of one's life (Veenhoven 2003). While the debate featured was not intended to be exhaustive about the terms wellness, quality of life, life satisfaction and happiness, it does however, highlight current definitional challenges and the interchangeable usage of terms.

2.4 Historical context: hedonic and eudaimonic traditions

The historical context of wellbeing is important to the definition and subsequent use of the construct (Dodge et al. 2012) where, researchers contend that these roots of wellbeing have led to a diversity in wellbeing dimensions that have further created a confusing and contradictory research base (Pollard and Lee 2003).

Researchers identify two key approaches to understanding wellbeing, the hedonic and eudaimonic traditions (Kahneman et al. 1999; Waterman 1993). The hedonic approach emphasises concepts including, happiness, positive affect, low negative affect, and life satisfaction (Lyubomirsky and Lepper 1999; Kahneman et al. 1999; Diener 1984; Bradburn 1969), whilst the eudaimonic approach highlights positive psychological functioning and human development (Waterman 1993; Ryff 1989; Rogers 1961). Hedonic wellbeing can be defined as the presence of positive affect and absence of negative affect whereas, eudaimonic wellbeing focuses on living one's life in a deeply satisfying way (Ryan et al. 2006). Whilst, there is much wellbeing research focusing on the hedonic tradition (Deci and Ryan 2008), it is proposed that the eudaimonic tradition has the potential to make a significant contribution to the understanding of wellbeing (Henderson and Knight 2012).

Much research indicates that ancient texts like Aristotle's *Nicomachean Ethics* have influenced current conceptual understandings of wellbeing and happiness (Ryff and Singer 2008). It is put forward, that the two approaches to wellbeing, hedonia and eudaimonia, are based upon differing views of human nature (Deci and Ryan 2008). Despite this contention, it is proposed that there is a considerable intersection between hedonic and eudaimonic experience (Waterman 2008; Bauer et al. 2008). Moreover, Waterman and colleagues (2010) suggest that a person who experiences eudaimonic living will also experience hedonic enjoyment in their eudaimonic lifestyle yet, not all hedonic pleasure results from eudaimonic living.

Hedonic tradition

The roots of the hedonic tradition can be found in the works of Aristippus, Epicurus, Bentham, Locke, and Hobbes (Waterman 2008). It is maintained that the philosophers adopting this perspective, typically align wellbeing with positive affect derived from the satisfaction of desire, as such, pleasure, carefreeness and enjoyment are all deemed to be associated with wellbeing (Diener 2009). In general, hedonic philosophers have held the belief that humans were interested in maximising pleasure and minimising pain as a means of making the most of what is good in life (Henderson and Knight 2012). Usually, hedonic philosophers took the subjectivist position, holding that the individual was best equipped to define how well they are (Henderson and Knight 2012).

The hedonic tradition parallels Bentham's utilitarian view that humans are the soul masters of pleasure and pain and it is for them to decide what ought to be done (Henderson and Knight 2012). This is the hedonic assumption, that humans are motivated by the optimization of individual pleasure, underpinning the political paradigm of neo-classical economics - where pleasure is derived from monetary exchange in the market economy (Wiseman and Brasher 2008). This is philosophically opposed to the eudaimonic tradition (Deci and Ryan 2008).

Eudaimonic tradition

The philosophical roots of eudaimonia can be traced back to Aristollian principles (Ryan et al. 2006) and are also linked to philosophers such as Plato and Zeno of Citium (Grindle 2012). For Aristotle, the achievement of human wellbeing is embedded in a deeper and broader notion, than merely the attainment of pleasure and the avoidance of pain. Aristollian 'eudaimonic wellbeing' outlines how humans are able to find meaning and fulfill their true potential, which is stated to be realised in collective and social relationships (Aristotle 1952). For Aristotle, the pathway to wellbeing was achieved through living authentically or true to one's 'daimon' (Norton 1976). Furthermore, the hallmark of a good life was in the quest for meaningful goals both individual and societal

(Keyes and Annas 2009). From this perspective, community wellbeing can be viewed as being a determinant of individual wellbeing (Wiseman and Brasher 2008).

There are a range of variations in the definitional use of eudaimonia (i.e. Kashdan et al. 2008; Ryan, et al. 2008; Waterman 2007; Seligman 2002; Ryff 1989) yet, it can be conceptualised as an overarching term that would include psychological wellbeing, virtue and excellence, intrinsic motivation and authenticity, flow and full functioning, meaning and purpose, and a concern for others (Wong 2011). A definition, that has been used to differentiate eudaimonia from hedonia, emphasises that eudaimonia is reflected in living in a manner which actively conveys excellency of either character or virtue (Haybron 2000). Much research supports the notion that eudaimonia refers to a way of living, not a psychological state or outcome, more specifically it focuses on what is deemed to be intrinsically worthwhile to humans (Ryan et al. 2006).

While much contention still remains, the majority of psychologists propose that both the hedonic and eudaimonic approaches underscore significant features of wellbeing (Henderson and Knight 2012). Thus, this has led to a growing number of integrated wellbeing conceptualisations (Huppert and So 2009) that combine features of hedonic and eudaimonic wellbeing, which Seligman (2009) refers to as 'flourishing'. Researchers investigating eudaimonic and hedonic pathways maintain that a life containing both types of pursuits will ultimately achieve the highest level of wellbeing (Huta and Ryan 2010). In Aristotle's vision of a good life, positive emotional experiences were not fundamental, however he did recognise that eudaimonic action could result in hedonic pleasure (Kashdan et al. 2008).

Potential outcomes

Research reveals a host of potential beneficial outcomes to eudaimonic living. It is proposed that people high in eudaimonic living tend to behave in more pro-social ways (Waterman 1981), benefiting the individual as well as the collective at family and societal levels (Ryan et al. 2006). People with intrinsic goal motivation, are reported to be less likely to engage in Machiavellian behaviour and be more predisposed towards social interests (McHoskey 1999). Eudaimonic pursuits have also been linked to a more lasting sense of subjective wellbeing, and an enhancement to baseline level wellbeing. Conversely, hedonia generally has more temporary effects (Ryan et al. 2006). Additional outcomes related to eudaimonic living include, life meaning (Huta and Ryan 2006; McGregor and Little 1998), subjective vitality (Ryan and Frederick 1997) and physical health (Ryff and Singer 2006; Williams et al. 1998). Hedonia has not however, been positively correlated to these outcomes (Ryan et al. 2006). Increasingly, research indicates that the promotion of eudaimonic behaviours and lifestyles, improves society as a whole, as members demonstrate greater care, concern, and responsibility for their

actions (Ryan et al. 2006; McHoskey 1999). In the past, wellbeing research has tended to have been more aligned with the hedonic tradition, yet it is increasingly clear that the eudaimonic perspective adds a significant perspective to the concept of wellbeing.

2.5 Wellbeing theories

Extant research underscores the influence of philosophy in inspiring the discipline of psychology thus; the above mentioned philosophical approaches have been further adapted to the psychology of wellbeing (Kahneman et al. 1999; Waterman 1993). Currently among researchers, there is greater agreement about hedonic wellbeing pathways versus those derived from the eudaimonic tradition (Kasdan et al. 2008). Thus, there has been an emergence of eudaimonic theoretical approaches which emphasise autonomy, self-realisation, mindfulness, authenticity, value congruence, and social connectedness (Huta and Ryan 2010; Ryan and Deci 2000). While noted that eudaimonia appears to be a more multifaceted concept, it is similar to hedonia in that it is considered at wellbeing and activity levels, where activities are seen as being intrinsically motivated and self-development as being a wellbeing pathway (Huta 2012).

It was recognised in early wellbeing research that there was a general lack of theory-based formulations (Ryff and Keyes 1995). The underpinnings of wellbeing, however, are significant, as the different theoretical foundations guide current multidisciplinary knowledge and practice. The review of wellbeing literature reveals that theories can be conceptualised as falling along a range between those that are more aligned with either the hedonic or eudaimonic traditions. Additionally, there are recent models that build a body of knowledge supporting an integrated theory of wellbeing that considers both eudaimonic and hedonic wellbeing.

Hedonic theories

Researchers support the notion that hedonic psychology can be expressed in theoretical conceptions (Deci and Ryan 2001). Despite there being a critique that there are more facts required before building a theory, the theories listed within this section are built upon the assumption that there is much malleability within human nature (Tooby and Cosmides 1992). Based on their prevalence in the research and potential salience to this study, the following hedonic theories will be outlined: subjective wellbeing; the hedonic treadmill; adaptation; set-point; and homeostasis.

Subjective wellbeing (SWB)

A significant feature of subjective wellbeing is that it may be defined from both hedonic and eudaimonic perspectives. The hedonic perspective suggests that wellbeing is derived from the maximisation of the pleasant effects of life and avoidance of unpleasant experiences and their related negative feelings (McMahan and Estes 2010). The eudaimonic perspective contends that humans cannot be truly well without engaging in self-development and making a contribution to the lives of others (Waterman 1993; Le Masurier et al. 2010). Thus, hedonic wellbeing focuses on happiness as a feeling and eudaimonic wellbeing emphasises reflective aspects of happiness, including fulfilment (Boniwell 2011).

The hedonic approach, focusing on wellbeing based on pleasures and happiness (Ryan and Deci 2001), is particularly influential to subjective wellbeing theory (Boniwell 2007). Research indicates that since the publication of Kahneman and colleagues' (1999) '*Well-being: the foundation of hedonic psychology*', SWB has been more linked with the hedonic approach to wellbeing (Deci and Ryan 2008).

Subjective wellbeing is distinguished as being subjective as it is for people themselves to evaluate the level that they experience wellbeing or wellness (Deci and Ryan 2008). An accepted definition of SWB is understood as experiencing a high level of positive affect, low level of negative affect and high degree of life satisfaction (Deci and Ryan 2008). Conversely, there are many researchers that accept Diener's definition of subjective wellbeing, as simply judging life positively and feeling good (Veenhoven 2008). From this perspective, a person has high levels of subjective wellbeing if they experience greater joy and life satisfaction, rather than experiencing unpleasant emotions like sadness (Diener et al. 1997).

The caveat however, is that strictly speaking the hedonic definition of wellbeing would only consider positive and negative affect as a means to index happiness, in light of the fact that life satisfaction is not a hedonic concept (Deci and Ryan 2008). Accordingly, researchers also support the notion of the integration of SWB into the eudaimonic approach (Deci and Ryan 2008).

Typically, the Satisfaction with Life Scale (SWLS) is used to measure the cognitive dimension of subjective wellbeing (Diener et al. 1985); and the affective dimensions are most often measured with the Positive and Negative Affect Schedule (PANAS; Watson et al. 1988), where a high level of wellbeing is indicated by high scores in life satisfaction and positive affect, in addition to a low score in negative affect (Kesebir and Diener 2008).

Research findings indicate that increases in SWB have positive effects, including, greater creativity, social contacts, work performance and physical health (Lyubomirsky et al.

2005). Additionally, SWB has been recognised as a means to broaden and build (Fredrickson 2004); where our perceptual horizon is broadened and greater resources are built or formed (Veenhoven 2008). Past research also indicates that SWB is reflective of the degree to which people's goals or needs are obtained or met (Nieboer et al. 2005). Studies reveal that there is an increasing demand for information pertaining to social conditions that promote subjective wellbeing among decision-makers as ideological correlations are no longer a focus of interest. Subjective wellbeing is acknowledged as an individual level concept (Veenhoven 2008), yet is noted to affect the functioning of social systems like work organisation and friendships (Veenhoven 2008).

Hedonic treadmill theory

The treadmill theory of happiness (Brickman and Campbell 1971) is proposed to make a significant contribution to psychologists' understanding of happiness. Diener and colleagues (2006) indicate that differing types of wellbeing change at various levels or even in different directions. Arguably, the most contentious aspect of the hedonic treadmill theory is the notion that people can only minimally alter long-term levels of happiness and life satisfaction (Brickman and Campbell 1971).

The theory is based on the work of Brickman and Campbell (1971) who indicate that people tend to return to a set point of happiness after major life events or traumas. Furthermore, it is proposed that a person's emotional system will adjust to life circumstances and responses as they compare to their past experience. Myers (1992) advises that every desirable experience, or exhilaration of success, is merely transitory. From this perspective, both good and bad events only temporarily affect happiness, as people adapt and return to hedonic neutrality (Diener et al. 2006). One of the implications and subsequent critiques of this theory is that individual and societal efforts to increase happiness are ultimately destined to fail (Diener et al. 2009).

While there is empirical support for parts of the hedonic treadmill theory (Bonanno et al. 2004; Lucas et al. 2003), there is mounting empirical evidence indicating the range of variability in individuals' reactions (Mancini et al. 2008). For example, Diener and colleagues (2006) suggest that the theory requires important modifications.

Specifically, recommending five amendments:

- individual set points are not neutral;
- humans have different set points which depend upon their temperament;
- a single person may have multiple set points;
- wellbeing set points can change under some circumstances; and
- adaptation to events, differs between individuals (Diener et al. 2006).

One of the significant contributions of the hedonic treadmill theory, arguably, is that it provides an explanation about how people with greater resources are often not any happier than those with few resources and people with severe problems are even quite happy (Diener et al. 2009; Frey and Stutzer 2002; 2001). Therefore, this research played a role in further understanding the concept of happiness. This research, also led to the development of the theoretical conception in the form of adaptation, dynamic equilibrium, set-point, and homeostasis theories of subjective wellbeing.

Adaptation/ Dynamic equilibrium/ Set-point/ Homeostasis theory

The theories of adaptation, and dynamic equilibrium, set-point and homeostasis have all developed from a very similar set of assumptions, that individuals have differing yet, constant levels of subjective wellbeing based on their personality traits and genetics. These theories, their related contributions and critiques are further discussed in the context of their contributions to the theoretical development of wellbeing.

Adaptation Theory

The adaptation theory was developed by Brickman and Campbell (1971), which acknowledges that individuals largely return to a baseline level of wellbeing, later referred to as their set-point, after experiencing significant life events. There are many psychologists that support the theory of adaptation based on the increasing evidence (Diener et al. 2006). Past research indicates that external conditions in a person's life are only weakly correlated to happiness (Diener et al. 1993; Campbell et al 1976). For example, research indicates that blind people did not have differing levels of happiness than their sighted counterparts (Feinman 1978). More recent studies indicate that a strong form of adaptation theory is unsustainable, it is moreover contended that adaptation may be a slow process and in some instances may never be complete (Diener et al. 2006).

The application of adaptation theory to practice would indicate that for an intervention to be effective it needs to be able to change a person's baseline wellbeing. This can only be determined through longitudinal studies measuring whether the effects of the intervention were temporary. To practitioners, adaptation theories may provide insight into programme design that may have a greater chance of long-term success (Diener et al. 2006). Whilst some researchers have likened the act of trying to be happier to that of trying to be taller (Lykken and Tellegen 1996), more recent studies reveal that up to 40%

of an individual's wellbeing can be determined by intentional activity (Lucas 2007). Another, recent finding is that there are long-term fluctuations in SWB, and adaptation are not always predictable (Diener et al. 2006).

Dynamic equilibrium theory

Heading and Wearing (1992) aiming to extend SWB theory, connect personality, life events and subjective wellbeing, in the dynamic theory of equilibrium. Their findings indicate that a person's 'equilibrium levels' are a facet of 'well'-being and 'ill'-being and that personality and life events, could be viewed as being in dynamic equilibrium. In this vein, individuals would view equilibrium as a state that would be worth retaining (Herzlich 1973). The primary focus of their research interest focuses on how people cope with change and how levels of wellbeing are affected (Heading and Wearing 1992).

Set-point theory

Set-point theory was developed by Lykken and Tellegen (1996) and also focused on connections between constant characteristics, life events and subjective wellbeing. Contentious findings from their research led to conclusions that subjective wellbeing is mainly pre-determined and that there is little that can be done by either the individual or public policy to enhance it (Sheldon and Lyubomirsky 2004; Lykken 2000).

Set-point theory is held, by some researchers, to be the dominant theory within subjective wellbeing research (Kuhn 1962). The theory proposes that long-term subjective wellbeing in individuals remains constant, due to personality traits and genetic factors (Headey et al. 2008). Thus, the main claim of the theory is that while there may be short-term vacillations, subjective well-being does not tend to change in the long-term (Headey 2008). It is contended, that while life events may influence temporary vacillations in their wellbeing, reversion to their set-point will soon occur due to personality traits, particularly levels of neuroticism and extroversion. It is suggested, that until recently, the propositions that subjective wellbeing is not altered had not been tested (Headey et al. 2008).

There is recent empirical evidence that tend to contradict certain aspects of set-point theory as it was understood (Diener et al. 2006; Headey 2006; Easterlin 2005; Huppert 2005). Recent empirical studies confirm that while happiness levels do remain moderately stable over time, this does not discount the occurrence of large and lasting changes (Headey 2010; Lucas 2007).

Homeostasis theory

The most recent extension of this theoretical progression, can be traced back to Brickman and Campbell's (1971) work, the homeostasis theory (Cummins 2010). From this view, the term equilibrium is now replaced by homeostasis and life events are now referred to as challenges. The focus within this theory is on the particular strength of a challenge and the impact on an individual's level of subjective wellbeing (Cummins 1998). It is proposed that when a person reports a level of SWB that is outside of their set-point range, they have disconnected from their set-point mood-affect. This is further explained by the idea that when data was being collected, the individual was overcome by an emotional state that in turn overwhelmed their homeostasis levels (Cummins 2010). Arguably, a significant implication related to their findings is that external and internal human resources will aim to restore homeostasis yet, when the resources are insufficient, the perceived level of challenge will be lowered to a point whereby homeostasis can be restored (Cummins et al. 2014). In this situation it is advised that the return to the set-point will be determined by a person's adaptive resources, which include money and interpersonal relationships, paired against the strength of the challenge (Tomy et al. 2015).

This theory was further developed in the theories of adaptation (Brickman and Campbell 1976), dynamic equilibrium (Heading and Wearing 1992), set-point (Lykken and Tellegen 1996) and homeostasis (Cummins 2010). These subjective wellbeing theories explore the role of a person's life events and external resources and their return to a genetic set-point of wellbeing. Hedonic theorists tend to be sceptical of the positive effects of interventions on a person's long-term happiness or wellbeing. Conversely, eudaimonic theories, have often been developed as a reaction to purely subjective hedonic wellbeing theories, and will be evaluated as a potential means to contextualise a synergistic alliance between public health and tourism.

Eudaimonic theories

Eudaimonic theorising emerged originally as a challenge to subjective wellbeing with its focus on contentment, feeling good and life satisfaction (Bryant and Veroff 1982; Andrews and Withey 1976). Thus, eudaimonic wellbeing theory (EWB) denotes the quality of life a person derives from fulfilment of their goals to reach their greatest potential (Waterman 2008; Sheldon 2002). Eudaimonic wellbeing is proposed to have emerged to accompany and diverge from subjective wellbeing as a means of studying and understanding the quality of life (Kashdan et al. 2008; Ryan et al. 2008). Moreover, there are some researchers that use EWB synonymously with positive psychological functioning (Seligman 1999).

There are two main theories that are suggested to be associated with eudaimonic wellbeing - psychological wellbeing theory (Ryff and Singer 1998) and self-determination theory (Deci and Ryan 2000). Both of these theories are recognised as being primarily prescriptive as they specify mainly how wellbeing is to be attained (Deci and Ryan 2000).

Psychological wellbeing (PWB)

Psychological wellbeing (PWB) theory contends that eudaimonic wellbeing is attained through high levels of relatedness, autonomy, personal growth, self-acceptance, purpose in life, and environmental mastery (Ryff and Singer 1998). Ryff and Singer (1998) propose that the dimensions of psychological wellbeing result from a life well lived. Psychological wellbeing is differentiated from eudaimonia as it is argued to be more of a measure of eudaimonic living outcomes. Research indicates that PWB outcomes can yield outcomes akin to healthy psychological and physical functioning and the absence of psychopathy and disease (Ryan et al. 2006).

Based largely upon her reaction to the weighted focus on the affective pleasure component of SWB, Ryff (1989) developed the six dimensions of psychological wellbeing (Kjell 2011). Together these dimensions represent the Scales of Psychological Wellbeing (SPWB) (Ryff and Keyes 1995).

The questionnaire for eudaimonic wellbeing (QEWB) was developed based on the assertion that psychological wellbeing contain a more narrow definition of eudaimonia, namely a subjective state, which is the quest for virtue, excellence and self-realisation (Waterman 2008). The QEWB also involves six dimensions: self-discovery; perceived development of one's best potentials; a sense of purpose and meaning in life, investment of significant effort in pursuit of excellence, intense involvement in activities, and enjoyment of activities as personally expressive (Waterman 2008).

Past research supported the notion that psychological wellbeing was greater in members higher in the social hierarchy however, recent findings indicate that there is significant resilience among those both within lower socioeconomic classes and who have encountered major life challenges (Markus et al. 2004; Ryff et al. 2004). Thus, challenging the Hellenic conception of eudaimonia only being able to be realised by the more privileged members of society (Ryff and Singer 2008).

Self-determination theory (SDT)

Self-determination theory (SDT) suggests that wellbeing is achieved through the satisfaction of psychological needs for relatedness, autonomy, and competence (Deci and Ryan 2000). Further, it is suggested that if these needs are satisfied, it will allow people to flourish, yet if they remain unsatisfied, wellbeing will be challenged (Deci and Ryan 2000). Self-determination theory posits that these three psychological needs are

imperative to psychological growth, integrity, wellbeing, experiences of vitality (Ryan and Frederick 1997), and self-congruence (Sheldon and Elliot 1999). Moreover, the theory underscores the importance of need fulfilment, as it is viewed as the aim of life that explains meaning, purpose and action (Deci and Ryan 2000).

There are fundamental points of departure from Ryff and Singer's (1998) eudaimonic approach. While, Ryan and Deci agree that eudaimonia includes autonomy, competence and relatedness, they contend that the SDT approach addresses these principles as a means to foster eudaimonia whereas, Ryff and Singer's approach seeks to define wellbeing (Ryan and Deci 2001). Similar to Rogers' (1963) suggestion that emotional states reveal processes of valuation, SDT research uses measures of SWB to assess wellbeing (Ryan and Deci 2001). As such, measurement tools within self-determination theory, tend to vary depending on the contexts studied (Kjell 2011) and include: a focus on relationships (La Guardia et al. 2000) and a focus on the context of work (Deci et al. 2001).

Eudaimonic theories stress the significance of creating opportunities for people to engage in eudaimonic activity that will ultimately lead to enhanced levels of psychological wellbeing. Similarly, it is proposed that eudaimonic wellbeing is achieved through participation in activities which parallel participants' personal values (Waterman 1993) or personality traits or strengths (Seligman 2002). Eudaimonic theories indicate that activities which satisfy psychological needs nurture sustainable wellbeing, while activities that satisfy the want for pleasure (hedonic behaviours) do not (Steger et al. 2008). Thus, these eudaimonic theories offer a starting point for decision-makers to identify eudaimonic activities and associated eudaimonic behaviours.

Integration theories

It is contended that a balance in conceptual approaches to wellbeing is necessary (Ryff and Singer 2008) further requiring an evaluation of the catalysts of individual flourishing, as well as the optimal functioning of social institutions (Ryff and Singer 2008). While there has been much research that has made the distinction between hedonic and eudaimonic wellbeing (Gallagher et al 2009), contemporary research acknowledges that hedonic and eudaimonic approaches represent important elements of wellbeing (Henderson and Knight 2012; Kashdan et al. 2008). That said, recent studies have begun to examine potential means for integrating hedonic and eudaimonic components of wellbeing into a full model (Keyes 2007). To date, however, findings have been inconclusive, thus it is still uncertain as to whether current models can or should be integrated (Gallagher et al. 2009).

Presently, there are few studies that examine how models of eudaimonic and hedonic wellbeing can be integrated into the complete structure of wellbeing (Gallagher et al 2009). Past research contends that a framework that emphasizes the interdependencies within wellbeing research, may achieve an overall increase in wellbeing (Kjell 2011; Huta and Ryan 2010). Many psychologists now recognise the merits of both hedonic and eudaimonic approaches, which have led to an integrated wellbeing conceptualisation, often termed 'flourishing'. Furthermore, researchers recommend that future research abandon dichotomous thinking in order to view the potential interrelationships between hedonia and eudaimonia. Thus, there is a recommendation that eudaimonia and hedonia ought to be considered mutually inclusive and that they function in a synergistic fashion (Henderson and Knight 2012). Whilst, there have been past empirical studies examining an integrated model of wellbeing (Keyes et al. 2008), they still only provide preliminary evidence supporting this multidimensional conceptualisation.

Wellbeing Theory

One of the first integration theories to be proposed is the Wellbeing Theory, which was formerly known as the Authentic Happiness Theory (Henderson and Knight 2012) in it, Seligman (2012) proposes the idea that wellbeing can be understood as an amalgam of five scientific components namely: positive emotion; engagement; relationships; meaning; and accomplishment (PERMA).

The first component within Seligman's theory is pleasant life or *positive emotion* and is what hedonic theories promote (Seligman et al. 2006). This component includes present, past, and future positive emotive states. The benefits associated with increased positive emotions are suggested to be lower levels of depression and anxiety (Seligman et al. 2006). Additionally, evidence supports the assertion that positive emotions may also offset the damaging effects of negative emotion on attention, creativity, and physiology (Fredrickson and Branigan 2005).

The second component of the theory is *engagement* or an engaged life that is pursued through engrossment in work, intimate relations, and leisure (Csikszentmihalyi 1990). This desired state is referred to as 'flow', as a psychological state or experience when immersed in engaging activities (Csikszentmihalyi 1996). One of the ways in which Seligman (2002) proposed to improve engagement is to determine people's greatest talents and find opportunities for them to be used more often, these highest talents are referred to as 'signature strengths' (Peterson and Seligman 2004). The reported benefits of greater engagement include lower levels of both anxiety and depression (Nakamura and Csikszentmihalyi 2002).

High levels of engagement have been linked to:

- An individual having clear goals and being intrinsically interested in the task;
- The task offering a challenge which meets the skill level of the individual;
- The task providing immediate feedback to the individual; a personal sense of control is retained over the activity; and
- A merging between action and awareness, a complete immersion (Csikszentmihalyi 1996).

Within this theory the dimension of engagement parallels elements of 'flow' theory, which can be defined as an absorption in an activity where skill and challenge are well matched, both being high (Csikszentmihalyi 1997). Flow has been linked to eudaimonia in the form of activities to achieve this state and promote personal growth (Waterman 1993).

The third component of the wellbeing theory is *relationships*, which refers to the positive influence that positive relationships have on wellbeing. Within this theoretical construct positive relationships are suggested to be connected to the benefits of emotion or meaning or accomplishment (Seligman 2011). Furthermore, it is acknowledged that positive relationships are fundamental to the success of *Homo sapiens* (Jayawickreme et al. 2012).

The fourth component in Seligman's theory involves the quest for *meaning* that entails an individual using their signature strengths to contribute to something that is bigger than one's self, for example, community organisations. In addition, the interaction with the institution or organisation, promotes both a sense of satisfaction and a belief that the person has lived well (Nakumura and Csikszentmihalyi 2002). From this perspective, meaning is attained through using individual qualities and strengths to serve and belong to something that is larger than oneself (Jayawickreme et al. 2012).

The fifth component of *accomplishment* is motivated intrinsically and is not tied to winning, but is driven by the need for mastery and competence (Jayawickreme et al. 2012). Accomplishment can be understood in terms of success, mastery or achievement at the highest possible level within a specific area (Ericsson 2002).

Flow theory

It is established that flow theory synthesises hedonic and eudaimonic approaches to wellbeing (Waterman 1993). Flow theory is contended to be hedonic, as it impacts subjective wellbeing through the promotion of the experience of happiness in the moment (Moneta 2004). Flow also fits within the eudaimonic perspective as it encourages the mastery of difficult task therefore promoting lifelong growth (Moneta 2004).

The concept of 'flow' refers to a state where a person becomes so immersed in an activity that, there is nothing else that matters, consequently leading to greater levels of happiness. The flow theory, while not specifically identified within the literature as an

integrated theory, potentially offers a frame for decision-makers to consider in wellbeing promotion in both local public health and tourism contexts.

According to Csikszentmihalyi (1975) flow or optimal experience can be characterised by six dimensions: merging of action and awareness; limitation of stimulus field and alteration of time; loss of self-consciousness; control of actions; clear goals and clear feedback; and autotelic nature. The dimensions of flow theory are reported to be associated with intense cognitive-affective state that have eudaimonic and hedonic features (Waterman 1993). Flow research, has focused on individuals participating in numerous sports (Jackson and Eklund 2004), reading (Seligman and Csikszentmihalyi 2000), practising yoga (Philips 2005), whilst playing chess or when dancing (Jackson and Eklund 2004), and participation in music, games and other creative activities (Csikszentmihalyi 1999).

The Flow Scale (Csikszentmihalyi and Csikszentmihalyi 1988) measures levels of engagement in several activities. The eleven point scale where respondents rate a particular statement in relationship to a given situation, for example, 'I clearly know what I am supposed to do'. Most often, flow has been measured by the Experience Sampling Method (ESM) as well as with ESM related measures namely, Flow State Scale (FSS) and Dispositional Flow Scale (DFS) (Jackson and Eklund 2004). ESM represents a means to describe differences in self-reports about mental processes (Csikszentmihalyi and Larson 1987). The intent of ESM has been to study the cognitive, emotional and conative dimensions of experience or the flow state (Csikszentmihalyi and LeFevre 1989). As related to the engagement component of wellbeing, the measurement of flow represents the only measure, thus, measures of engagement are still lacking.

Eudaimonic theories of wellbeing affirm the significance of achieving a person's full potential through engagement in meaningful activities (Steger et al. 2008). Studies indicate that eudaimonic behaviours are more strongly related to wellbeing than hedonic behaviours (Steger et al. 2008). Thus, 'doing good' may be an important means by which people create meaningful and satisfying lives (Steger et al. 2008).

While integrated theories and more holistic, composite measures of wellbeing are important for researchers, there are still questions about the utility for decision-makers. There is the issue of weighting or alternatively coming up with a single summary measure. The counter argument however, being succinctly, would one desire to have a single number represent the wellbeing of an individual, community or nation (Forgeard et al. 2011).

Figure 4 summarises the main wellbeing theories and predominant measurement tools for each as identified within extant literature. This conceptualisation maps wellbeing

theories along a continuum ranging from eudaimonic to hedonic. Eudaimonic theories include Ryff's (1989) psychological wellbeing theory and Deci and Ryan's (2000) self-determination theory. The two main measurement tools are revealed to be the scales of psychological wellbeing (SPWB; Ryff 1989) and the questionnaire for eudaimonic wellbeing (QEWB; Waterman 2010). A review of past studies underpinned by SDT (Deci and Ryan 2000) indicates that there are various tools used to measure domains, depending on the specific context. At the other end of the continuum, hedonic wellbeing theories include: subjective wellbeing (Diener 1985), hedonic treadmill/adaptation theory (Brickman and Campbell 1971), set-point theory (Lykken and Tellegen 1996), dynamic wellbeing theory (Hedey and Wearing 1992) and homeostasis theory (Cummins 2010). Subjective wellbeing is most often measured using either the satisfaction with life scale (SWLS; Diener et al. 1985) or the positive and negative affect scale (PANAS; Watson et al. 1988). The wellbeing theory (Seligman 2012) and flow theory (Csikszentmihalyi 1990) are identified as integrated wellbeing theories which combine elements from eudaimonic and hedonic theories. The continuum presents the range of wellbeing theories to better inform public health and tourism agendas. The historical context of public health up to the present day will be outlined to highlight the potential levers and challenges to health and wellbeing promotion within the current study.

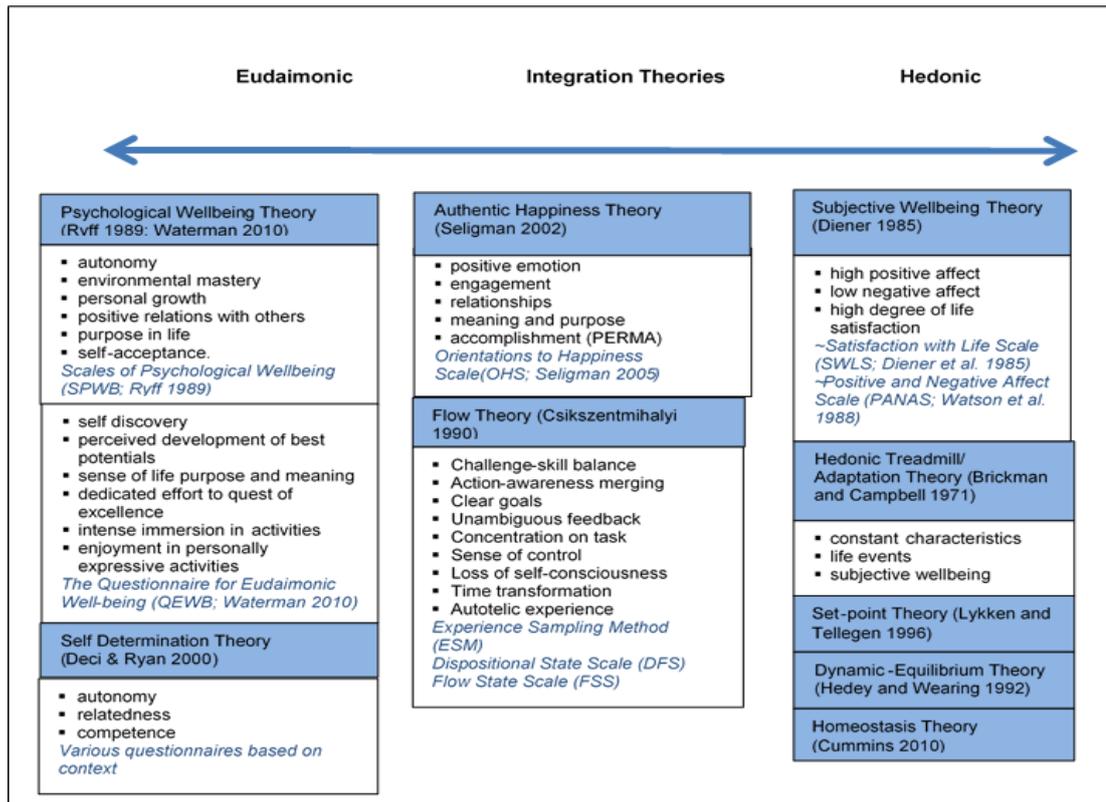


Figure 4: Wellbeing theory continuum

2.6 Public Health

Wellbeing theories are utilised to better understand and frame current health promotion approaches. The World Health Organisation’s definition of wellbeing is first evaluated in terms of its merits, potential interpretations and its relationship to health promotion. The reorganisation of the public health agenda to local authorities within the UK up to current policy directions will be outlined, to set the context for this study. The current public health agenda will be evaluated in relation to the theoretical underpinnings as connected to eudaimonic and integrated wellbeing theories. This focus does not presuppose that eudaimonic wellbeing theories are superior in any way to hedonic wellbeing theories, rather in seeking potential synergies between public health and tourism, these types of wellbeing theories may catalyse longer-term wellbeing and ultimately enhanced levels of social sustainability.

Legislation Empowering Local Authorities

The UK Local Government Act (2000), empowered local authorities to encourage economic, social, and environmental wellbeing within their jurisdictional area, where they

now have a statutory duty to improve the health and wellbeing of their local population (UK House of Commons 2015). Additional changes included the Local Government and Public Involvement Act 2007 and the Duty to Involve 2009 that allowed local authorities to devolve power to local communities. More recently, the UK Public Health White Paper (2010) proposes responsibilities for local council in regards to public health. The concept of wellbeing becomes increasingly salient in light of the UK government's empowerment of local authorities to promote wellbeing (Local Government Act 2000). Moreover, it is suggested that local government is now experiencing an unparalleled opportunity to carve out a new role. The UK government is in the process of pursuing a "localised" policy where functions of health improvement shift from regional to local council responsibility (Davies et al. 2014; Hartwell 2011). Instruments of local government, which include planning, transport, education, leisure, and housing, represent many of the fundamental levers for improved wellbeing (Hunt 2012; Aked et al. 2010).

Additionally, it is acknowledged that local government plays a significant role in building greater capacity for material and psycho-social wellbeing and nurturing conditions for citizens to reach their potential and enjoy a good life (HM Government 2010). This shift presents an opportunity for local level decision makers, aware of local conditions, to effectively enhance general levels of health and wellbeing (Hartwell et al. 2012). Furthermore, there is a growing recognition of the importance of multi-stakeholder collaboration in marrying policies for more effective outcomes towards community wellbeing (Hartwell et al. 2013; Aked 2010).

Increasingly, health research suggests that health promotion and prevention needs to be linked to individual responsibility and accountability for their health (Hunt 2012). Researchers recommend the creation of new models for positive health which reflect WHO's slogan, *health is our real wealth* (Hunt 2012; Shaw and Marks 2004). Shah and Marks (2004) recommend that any good, democratic government ought to promote a good life and a flourishing society to facilitate a happy, healthy, capable and engaged citizenry and wellbeing. From this perspective, wellbeing contributes to a person's development, their fulfilment and their ability to contribute to their community (MacKean and Chapman 2012; Shah and Marks 2004; Cuthill 2003). There is now a recognised need for the integration of all sectors, both locally and nationally, to work together to be fully engaged to encourage a scenario where citizens understand their health and how to protect it (Wanless 2002).

Historical context of public health policy and health promotion

Research suggests that historical interpretation could be used as an analytical tool to better understand public health decision-making and policy (Berridge 2000). Historically, public health policy has been conceptualised as four distinct waves of health activity that

bridge a connection between societal situations, thinking, and associated public health policy interventions (Davies et al. 2014; Hemingway 2011; and Hanlon et al. 2011; Lyon 2008). Further, it is proposed that each of these waves since the industrial revolution is associated with shifts in thinking around society and health (Hanlon et al. 2011; Szretzer 1997). Notably, research suggests that it is possible to connect links between the public health waves and notions about society, health and wellbeing (Hanlon et al. 2011). The historical trace of public health policies reveals the predominance of reductionist and reactionary approaches, traditionally responding to curing rather than preventing disease. Increasingly research supports the need for a fifth wave in health policy that would represent a shift to a proactive approach to health promotion (Davies et al. 2014; Hemingway 2011).

Fifth wave of public health policy

With the additional complexity accompanying the twenty-first century, the reductionist and reactionary approaches employed within public health seem to no longer meet current health challenges. There is growing recognition that current public health models, ideas and interventions seem inadequate when faced with the complex issues of the 21st century (Lyon 2008). Increasingly, research indicates that public health is an ineffective body based on the false assumption that the human body is a machine protected from disease and infirmity through interventions (Naidoo and Wills 2015).

Research indicates that a distinct 'fifth wave' of development is needed to address the current societal health challenges (Hanlon et al. 2011), where public health is not just supporting public health policy but is prompting the approach (Whitehead 2010). Public health has moved past being merely the science of identifying and removing infectious diseases. Current epidemiology is more complex as there is an interrelationship between genetics, environmental situation, and lifestyle choices. Researchers have acknowledged the limitations of reductionist thinking in healthcare for unravelling clinical and organisational challenges (McDaniel and Driebe 2001; Plsek and Grenhalgh 2001; Waldrop 1992). There is currently a recognised need to abandon past linear models to better respond to emerging patterns and prospects (Plsek and Grenhalgh 2001). Some have argued that a main challenge is that there is no conceptual model to guide the identification of social and political processes to either encourage or discourage public health policy development (Berridge 2000; Nathanson 1996).

It is suggested that the particular challenges around issues of obesity, inequalities, and the loss of wellbeing are not able to be mitigated through earlier or current strategies despite central government efforts (Hanlon et al. 2011). Additionally recent statistical analyses suggest that ill-health accounts for annual UK government spending of £10.4 billion where £4.2 billion is related to obesity, £3.5 billion to alcohol misuse, and £2.7

billion to smoking (HM Treasury 2015). Obesity rates across England are continuing to rise, particularly amongst disadvantaged children, further widening health inequalities (Health Survey for England 2014). While smoking rates have declined, one in five adults are smokers; and one in four are smokers in disadvantaged communities (ASH 2015). Excessive drinking is also most prevalent within the lowest socio-economic groups (UK House of Commons 2015). These are examples of challenges that are currently being faced, that if tackled effectively could improve the function of public health and lessen health inequalities (UK House of Commons 2015). This situation is further compounded by recent evidence to suggest that the current Conservative and Unionist government have been criticised for not developing effective strategies and policy to address health challenges of obesity, and smoking (Bosely 2016; Wallaston 2016). Recent evidence further emphasising that current models, ideas, institutions and interventions are now deemed to be ineffective in tackling the complexity in life within the 21st century (Naidoo and Wills 2015; Lyon 2008).

2.7 Health promotion

As advocated by the World Health Organisation (1986), health promotion is viewed as a process that empowers people to control their health, in order to better enjoy active, productive, lives. The health promotion era can be viewed as emerging at the same time as salutogenesis (Lindström and Eriksson 2006). Post World War II; there was a focus on the creation of conditions to support societal welfare, secured by the United Nations. One of the central concerns identified being the protection of human rights and freedoms, thus, within the domain of public health, the World Health Organisation was established.

This establishment of WHO also encompassed a new definition of wellbeing, described as being a state of complete physical, mental and social well-being, not merely the absence of disease (WHO 2006). This definition reflects the growing awareness that wellbeing is not simply the absence of mental or physical illness (Deci and Ryan 2001). Furthermore, researchers agree that health promotion needs a greater focus on health as opposed to disease (Morgan and Ziglio 2007; Kickbusch 2006). The new definition further broadens the conceptual understanding of the individual determinants of health being a facet of the physical (body fitness), mental (sense of coherence) and social dimension (accessing social support) (Bauer et al. 2006). The Ottawa Charter is recognised as being a central document to the conceptualisation of health promotion (WHO 1986). It views health as a process that enables people to develop through their resources, thereby allowing them to have a good life (Eriksson and Lindström 2008). Additionally, the Ottawa Charter views health promotion as a process that enables a person to have greater control over, their health improvements (Antonovsky 1996). The

Charter highlights the significance of communities being responsible for controlling their future (Davies et al. 2014; Hanlon et al. 2011).

One of the main challenges to health promotion is in the fact that much health theory has been related primarily to health-related behaviours (Dean 1996) yet health promotion is concerned with societal organisations and the underpinning theories and philosophies (Nutbeam and Harris 2004). As such, the general lack of theory has concerned many researchers (KickBusch 2006; Nutbeam and Harris 2004). The Healthy Cities Movement and the salutogenic approach are examples of societal level health promotion that are underpinned by theoretical constructs.

Healthy cities movement (HCM)

The Healthy Cities Movement (HCM) is an international movement that began in 1986 and represents a new view of health promotion (O'Neil and Simard 2006). The HCM is aimed at determining means to implement the Ottawa Charter for Health Promotion (WHO 1986). In addition, it is noted that the concept of healthy cities seeks to capture the need for liveable communities in the global context (Kegler et al. 2000).

The reorganisation of public health in the UK endorses the World Health Organisation's (WHO) Healthy Cities initiative which seeks to involve local governments in health development through processes of political commitment, institutional change, capacity-building, partnership-based planning and innovative projects (WHO 2012). Currently, there are 14 UK cities participating with an exponential increase expected with the widespread acceptance of the public health agenda (Hartwell et al. 2013). For participating cities, the main goal is to elevate health as a priority in local-level decision-making (Hancock 1993). The HCM initiative is recognised as being a highly political task requiring negotiation between various stakeholders. One of the issues frequently called into question is whether universal indicators are effective (O'Neil and Simard 2006).

Salutogenic approach

The word salutogenic emerges from the combination of words 'salus' which means health, and 'genesis' within refers to giving birth, thus literally meaning that which gives birth to health (Judd et al. 2001). In the past, the public health approach has been guided by a pathogenic perspective with a focus on disease or illness prevention. Cowley and Billings (1999) contend that the adoption of a salutogenic approach underscores the fundamental consideration of how health is created and maintained through health promotion. Additionally, Labonte (1996) suggests that the salutogenic approach to health promotion questions past policies influenced by economic rationalism

The salutogenic model of health promotion as proposed by Antonovsky (1996) offers an additional approach to pathogenesis (Antonovsky 1984). From this perspective ill health refers to disease, objective and subjective disorders (Bauer et al. 2006). Salutogenesis however, assesses a person's resources that contribute to positive health encompassing subjective wellbeing, objective fitness, optimal functioning and a meaningful life (Raphael et al. 1996). It is contended that in practice these two approaches operate in a complementary interaction, where humans are constantly using their resources to guard against health risk factors. Furthermore, it is acknowledged that humans can experience positive and negative health at the same time (Bauer et al. 2006). In the past, the majority of studies have focused on ill health and the pathogenic paradigm (Tones and Green 2004). That said this study will primarily focus on the frame of salutogenesis as it is connected to wellbeing theory and a potential means to promote long-term sustainable health.

One of the key shifts in approaches is in the focus on prevention rather than cure. A salutogenic or health-creation focus within public health, emphasizes factors that promote wellbeing rather than merely preventing disease (Lindstrom and Ericsson 2006). The fundamental question underpinning salutogenesis is what creates health, as opposed to the pathogenic need to determine the cause of disease (Antonovsky 1979). This salutogenic orientation as proposed by Antonovsky (1987) is a model for health promotion which focuses on salutary factors.

Salutogenesis is guided by three main aspects. The first is the focus on problem solving and finding solutions. Secondly, it reveals Greater Resistance Resources (GRRs) that assist people in moving towards positive health. Thirdly, it recognises that social systems within society serve as the means for building capacity, a Sense of Coherence (SOC) (Lindstrom and Eriksson 2006). Salutogenesis is comprised of three primary components: the health continuum; the story of the person; and health-promoting, salutary factors (Antonovsky 1987; Langeland et al. 2007). From this perspective, opposed to traditional pathogenic orientation, health is conceptualised as a continuum, which strives to understand what encourages a person to move towards the healthy end of the continuum. Thus, the story of the person becomes instrumental rather than the diagnosis and is seen as an open system in a dynamic relationship with external and internal conditions. Raeburn and Rootman (1998) indicate that the salutogenic view of health promotion is people-centred.

Salutogenesis focuses on the necessary resources for health and health-promoting processes. Antonovsky (1979) introduced the Sense of Coherence (SOC) as a result of his inquiry into why some people were able to stay healthy in stressful situations and others were not. Eriksson and Lindström (2008), indicate that the philosophy behind

salutogenic theory corresponds with the core of the Ottawa Charter. It is noted, however, that despite this fit, the salutogenic approach has been underutilised. It is moreover suggested that salutogenesis represents the main components of health promotion further leading to greater levels of wellbeing (Lindstrom 1994). Research suggests that salutogenesis is connected to building capacity for engagement and activities that enhance individual and community wellbeing (Judd et al. 2001).

Generalised resistance resources (GRR)

Research acknowledges the impact of the salutogenic model on the health promotion discussion and debate (Eriksson and Lindstrom 2008). Within the salutogenic model, generalised resistance resources explain how people move towards the healthy end of the health continuum. GRRs are individual property, collectives, or situations which promote successful coping from life stressors (Antonovsky 1996). The suggested significance of the GRRs is that they all assist a person to see the world cognitively, instrumentally and emotionally make sense (Antonovsky 1996). From this viewpoint, the sense of coherence (SOC) construct is said to have emerged.

Sense of coherence (SOC)

The Sense of Coherence scale was developed from interview narratives collected from Holocaust survivors. The SOC construct is grounded in the assumption that the manner in which people view their life will positively affect their health. This construct refers to a resilient attitude which assesses how people use their GRRs to cope with stressful situations (Eriksson and Lindström 2007). The Sense of Coherence is comprised of three dimensions, namely comprehension (cognitive component), manageability (the instrumental component) and meaningfulness (the motivational component) as it is connected to the interactions between an individual and their environment (Eriksson and Lindström 2008). It is proposed that a strong sense of coherence will help to both identify and use necessary resources for problem solving (Eriksson and Lindström 2008). The SOC scale is argued to be a reliable means to measure health and the quality of life (Eriksson 2007). That said, a noted challenge for future health promotion research is in the full realisation of the salutogenic approach being embedded within health policies and further building salutogenic societies.

Past research outlines the connection between salutogenic thinking and the theoretical model of flow (Lindstrom and Eriksson 2006). Figure 5, illustrates the connections between public health promotion, salutogenesis and flow theory, as it is framed as an integrated wellbeing theory; blending hedonic and eudaimonic components. Figure 4,

also summarises upstream and downstream approaches to public health and theoretical links to the integrated wellbeing theory of flow.

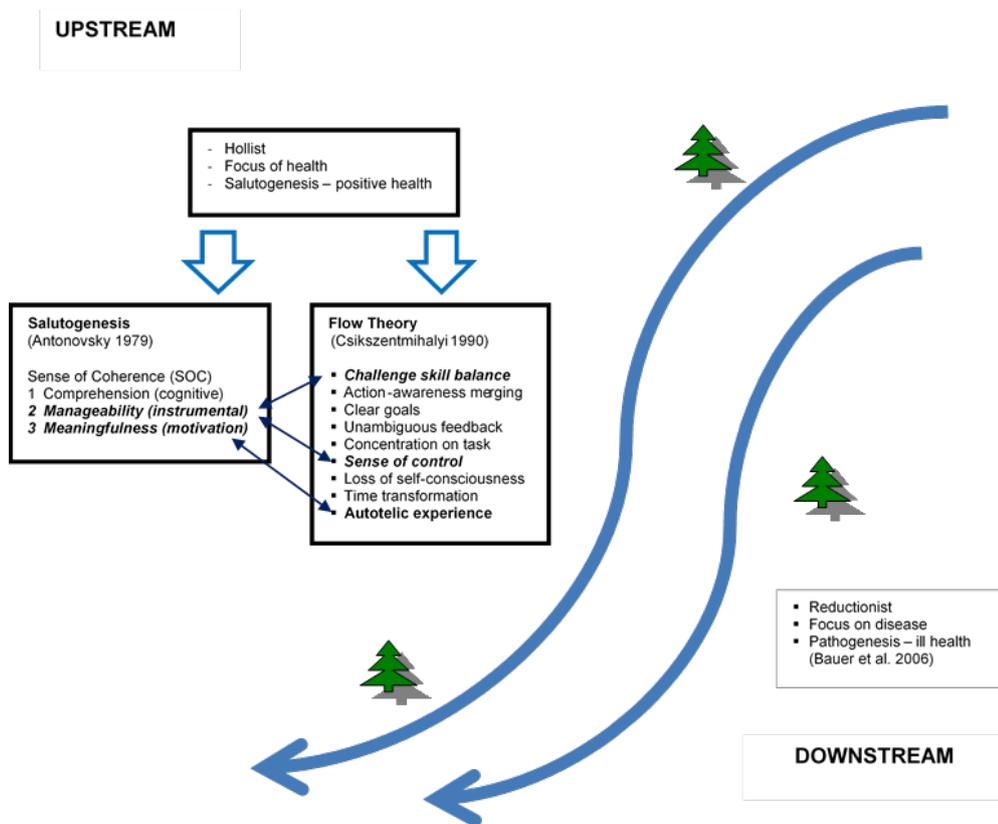


Figure 5: Approaches to health promotion – situating salutogenesis and wellbeing theory (Adapted from Antonovsky 1996)

Figure 5 depicts the main approaches that have been employed in health promotion, namely pathogenesis and salutogenesis, using the metaphor of a river. From this perspective, Antonovsky (1996) suggests that curative medicine focuses on those who are already drowning in the river whereas; preventive medicine is focused on those individuals that are in danger of being pushed into the river, upstream. In terms of upstream approaches to health promotion, the Ottawa Charter underscores the significance of health promotion and treating people holistically (Baum 1993). It is further indicated that holistic wellbeing is unlikely to be achieved within a system that is driven by market forces (Baum 1993). This type of system is suggested to have a downstream focus, with an interest in curing ill people, as opposed to an upstream focus with the potential to prevent injury and promote health. Upstream thinking is noted to be more possible in a publically funded institution, where profit is not the primary driver (Baum 1993).

The river metaphor, seeks to juxtapose upstream-salutogenic and downstream-pathogenic approaches to public health. In this vein, pathogenesis focuses on ill-health, disease, objective and subjective disorders (Bauer et al. 2006) and salutogenesis evaluates a person's resources which promote positive health incorporating objective fitness, subjective wellbeing, optimal functioning and a meaningful life (Raphael et al. 1996). The contention is that these two approaches are constantly interacting in a complementary fashion, where a person uses their resources to guard against risk factors.

Lindström and Eriksson (2006) reveal the connection between salutogenesis and flow theory, which is framed within this study as an integrated wellbeing theory, containing both hedonic and eudaimonic components. The SOC components, of manageability and meaningfulness can be viewed as having a parallel focus to that of flow theory. Manageability can be seen as being both the challenge skill balance and sense of control within the theoretical construct of flow (Csikszentmihalyi 1990). As well, SOC's meaningfulness can be viewed to run parallel to the autotelic experience within flow theory, which refers to an activity having purpose and meaning within itself.

To frame the potential connections between wellbeing, public health and tourism, past destination management research examines the ways in which tourism can contribute to tourists' wellbeing, community wellbeing and destination wellbeing. Alternative activity pathways and tourism typology examples are suggested as ways to promote eudaimonic wellbeing which may co-locate public health and tourism agendas.

2.8 Tourism and destination management

The concept of wellbeing within the local tourism context will be framed in terms of its 'fit' on the wellbeing theory continuum. Embedding local tourism within its philosophical roots and psychological theories presents an opportunity to compare and contrast public health and tourism strategies to approaches within the local authority. Furthermore, the understanding of the theoretical underpinnings of the current tourism approach aims to build a conceptualisation of how local public health and tourism agendas can be co-located. The tourism and travel industry are argued to play an important role in enhancing societal wellbeing and improving quality of life (Medina-Munoz and Medina-Munoz 2013; Chen et al. 2006) and ultimately creating healthier communities (Munthe 2008). It is suggested that the role of tourism policy is to develop a socio-economic environment enabling the sector to sustainably prosper (Ritchie and Crouch 2003). The diversity within the tourism industry presents opportunities for synergies with public health. This review of literature also seeks to situate this study within new and emerging agendas

concerned with health, wellbeing and tourism. To date, the potential of tourism and public health to cooperate, in improving public and visitor wellbeing, has not been evaluated.

In the last decade, there has been a proliferation of wellbeing tourism research (Kim et al. 2013; Dolnicar et al. 2012; Bushnell and Sheldon 2009; Moscardo 2009). In the review of tourism destination research there is an increasing focus on connections between eudaimonic wellbeing within a tourism context (Bosnjak 2016; Kler and Tribe 2012; Coghlan and Fennel 2010; Pearce 2009; Fennel and Malloy 2007; Fennels 2006; de Botton 2002). In addition, eudamonia is linked to the concepts of personal expressiveness and intrinsic motivation which have both been applied to tourism (Fielding et al. 1992), or volunteering (Bonjear et al. 1994). In a study by Voight and colleagues (2010), experiences at lifestyle resorts were identified as being mainly eudaimonic, near the middle of the continuum, as hedonic outcomes are often significant by-products of eudaimonic experiences.

Past research challenges the preferencing of eudaimonic over hedonic wellbeing (Kasdan et al. 2008); as it is agreed that both hedonia and eudamonia contribute to states of optimal psychological wellbeing. In light of this evidence, this study seeks to understand how the inclusion of eudaimonic theories or integrated theories may synergise local public health and tourism units. This does, in part make the assumption that from past literature reviewed; public health tends to have a more eudaimonic alignment, whereas mass tourism can be viewed from a more hedonic perspective. This study, aims to evaluate the potential for wellbeing theory to catalyse a strategic alliance.

Local tourism governance

A study of UK local government tourism strategies found that local governments were predominantly concerned with tourism expansion and the benefits of revenue and employment (Long 1994). More recently a study of local councils within Australia indicated that tourism units were mainly embedded within economic development units with 70 per cent of respondents revealing that council was most interested in tourism's economic contributions (Carson and Beattie 2002). Additionally, these results revealed the pro-economic focus of tourism officers and the impact of this perspective on their subsequent approach to job tasks (Beaumont and Dredge 2010).

Local tourism agendas, while continuing to have a pro-economic thrust, often reflect sustainability, community wellbeing and social cohesion (Beeton 2006; Murphy and Murphy 2004). It is contended that greater understanding of local tourism governance is imperative to achieving improvements in tourism management structure and practice (Bell 2004; Evans 1995). Important to the context of local governance is how the role of hegemonic beliefs or world views can shape strategy and policy (Beaumont and Dredge

2010). Arguably, this too can be a starting point for recognising the points of both intersection and departure and better understanding intra-organisational conditions for catalysing a strategic alliance between tourism and public health.

2.9 Wellbeing or wellness tourism

It is proposed that in the wake of increasing global competition, destinations can be highly interchangeable thus, destination marketing organisations (DMOs) are constantly being challenged to attract travellers (Pike and Ryan 2004). Researchers further contend that promoting the wellbeing of tourists should be integrated into any tourism destination management or marketing strategy (Rodrigues et al. 2010). Moreover, it is indicated, that the most popular types of destinations, coastal areas, aim to satisfy physical needs whilst also addressing the issue of psycho-social need fulfilment (Buhalis 2000). Current research indicates that existing destination and management marketing strategies should pay more attention to the eudaimonic concept, as it may provide competitive advantage, open new development and marketing opportunities, win tourism loyalty, and make destinations more attractive (Ritchie and Crouch 2003). Thus, strategic partnerships between tourism and health decision-makers may be an opportunity to enhance destination management strategy. Within this context, the consideration of tourist wellbeing, community wellbeing and destination wellbeing may present areas for synergies between wellbeing, public health and tourism.

Wellness tourism is recognised for its significant role in the contemporary global tourism market, being regarded as one of the most attractive niche products (Rodrigues et al. 2010). It is proposed, that wellness tourists are active health seekers that are highly motivated and play an involved role in maintaining and enhancing their health (Smith and Kelly 2006). Researchers posit that this type of tourism aims to balance the body, mind and soul (Smith and Puczko 2009) thus, integrating physical activity and mind relaxation (Rodrigues et al. 2010). Current estimates place the value of wellness tourism at 106 billion (\$US) per year globally, which doubles that of medical tourism. The number of international wellness tourists in 2010 was estimated to be 17 million (Global Spa Summit 2011), and it is forecast that wellness tourism will increase annually by up to 10% (Rodrigues et al. 2010).

2.10 Tourism, wellbeing and tourists

The current economic circumstances and associated levels of stress have contributed to the increasing demand for wellbeing holidays and experiences (Hartwell et al. 2016; Gustavo 2010). The last decade has witnessed a swell in research connecting tourism, wellbeing and tourists (Filep 2014; McCabe et al. 2010; Voight et al. 2010; Sonmez and

Apostopoulos 2009 Moscardo 2009). Past research reviewed, established the connections between wellbeing, tourism and tourists, particularly the role of holidays and tourists' wellbeing.

Role of holidays

Research supports the notion that being on holiday will improve a tourist's wellbeing and it will ultimately contribute to their psychological health (Voigt et al. 2010). Furthermore, vacations have been revealed to enhance one's mood, and provide time for fun, pleasure or relationships (Voigt et al. 2010). Additionally, it is noted that vacations may also promote self-development, personal growth and discovery of one's true self (Voigt et al. 2010). Recent studies have examined the role of different tourism markets on tourists' wellbeing: social tourism (McCabe and Johnson 2013; Morgan et al. 2015); tourism for elderly populations (Kim et al. 2015); and tourism for youth markets (Eusebio and Carneiro 2014). Increasingly, research reveals that there are positive wellbeing benefits accrued from tourism across the range of tourist typologies (Hartwell et al. 2015).

Tourists' experience

Research indicates that tourism has the potential to promote Seligman's (2002) Authentic Happiness Theory and its dual focus on pleasure and meaning. Moreover, Yeoman (2008) emphasises the importance of meaning in future tourism research as it applies to tourist experiences. For example, travel and holiday experiences have been connected to the production of transformational meanings and reports of self-change (Alexander 2010; Noy 2004). More specifically, Noy's study of backpackers found that their narratives prominently featured themes of both authenticity and adventure as part of their self-change.

Applied to tourism research, the AHT could broadly interpret that tourists' experience positive emotions, meaning and engagement further promoting hedonic and eudaimonic wellbeing (Filep and Deery 2010). One of the notable strengths of the AHT is its ability to capture both the emotional or transient aspects of wellbeing in addition to aspects of tourists' wellbeing that are meaningful and have greater longevity. (Filep and Deery 2010).

Past studies have connected the components of the Authentic Happiness Theory to the phases of the tourist experience, as depicted in Table 1.

Happiness Theory Component	Tourist Experience Phase	Evidence
Positive emotions	Anticipation	Evaluation of tourist motivation
Engagement	On-site experience	Measuring flow at tourist sites
Meaning	Reflection	Assessment of tourists' holiday reflections

Table 1: Authentic happiness theory and tourists' experiences (adapted from Filep and Deery 2010)

From this perspective, positive emotions are linked to the anticipatory holiday phase, and engagement and meaning are tied to the onsite and reflective phases. Caldwell and Smith (2005) acknowledge that not all tourism experiences and activities will promote psychological wellbeing or healthy outcomes. Nevertheless, there is scant research assessing the links between tourism experiences and positive hedonic or eudaimonic outcomes (Voigt et al. 2010).

This frame for understanding tourist experiences is depicted here to conceptually map an integrated wellbeing theory approach to an aspect of tourism research. In particular, these findings, related to tourists' experiences, present a means to understand the components of positive emotion, engagement, and meaning in a tourism planning context.

2.11 Tourism, wellbeing and the destination community

Researchers contend that once a community becomes a tourist destination, the lives of the residents will be either positively or negatively affected (Jurowski et al. 1997). A wide range of recent research has examined the role of tourism on the destination community (Himmelgreen et al. 2012; Cecil et al. 2010; Meng et al. 2010; Bauer 2008). Research highlights many of the negative impacts of tourism on the destination community which include traffic congestion, crime rates and low wages (Meng et al. 2010; Ghani et al. 2013) However, it is advised that these findings have been based on the use of objective measures which fail to capture how community members are actually feeling about tourism (Hartwell et al. 2016). Subsequently, this has led to greater use of subjective wellbeing measures to better understand the actual impact of tourism on community members' wellbeing (Kim et al 2013; Aref 2011; Nawijn and Mitas 2012). As a potential area to promote greater community level wellbeing through leisure activities, Stebbins (1997) model of leisure activities suggests means for achieving greater eudaimonic wellbeing.

Leisure activities

Past research reveals how casual and serious leisure activities are connected to hedonic and eudaimonic wellbeing, thus offering a perspective to consider in local public health and tourism planning and management (Thurnell-Read 2016; Heo et al. 2010; Hutchinson and Kleiber 2005). In this model, casual leisure is viewed as being an intrinsically rewarding, short-term pleasurable activity that requires no special training to enjoy. In simple terms, it can be referred to as 'doing what comes naturally' (Stebbins 1997). Casual leisure activities like relaxation, active entertainment and sensory stimulation, are all recognised as being hedonic.

Casual leisure is represented in no less than six types: play, relaxation, passive entertainment, active entertainment, sociable conversation and sensory stimulation (Stebbins 1997). Past research indicated that these activities all share hedonic qualities in that they all produce a significant amount of pleasure. The hedonic nature of casual leisure activities is argued to be the reason why it fails to promote an optimal experience for its participants (Thurnell-Read 2016; Stebbins 1997). Conversely, serious leisure is defined by activities requiring special skills and knowledge, and may not always be entirely pleasurable, at times involving embarrassment or danger (Stebbins 2008).

With regard to serious leisure activities, participants describe their involvement as being satisfying and rewarding rather than pleasurable or enjoyable (casual/hedonic) (Stebbins 1997). Past research proposed that participation in serious leisure activities has been connected with greater SWB (Cheng 2010; Lu and Argyle 1994), specifically through the psychological mechanisms of: mastery, meaning, and affiliation (Newman et al. 2014). Research indicates that those participating in serious leisure represent a minority of the population, as compared to those participating in casual leisure (Stebbins 1997). Additionally, research reveals that participants in serious leisure activities, also value participation in casual leisure pursuits, yet the serious level of participation, achieved the greatest levels of wellbeing (Lui 2014; Rojek 1995). Figure 6, depicts both serious and casual leisure activities as they can be mapped along a wellbeing theoretical continuum.

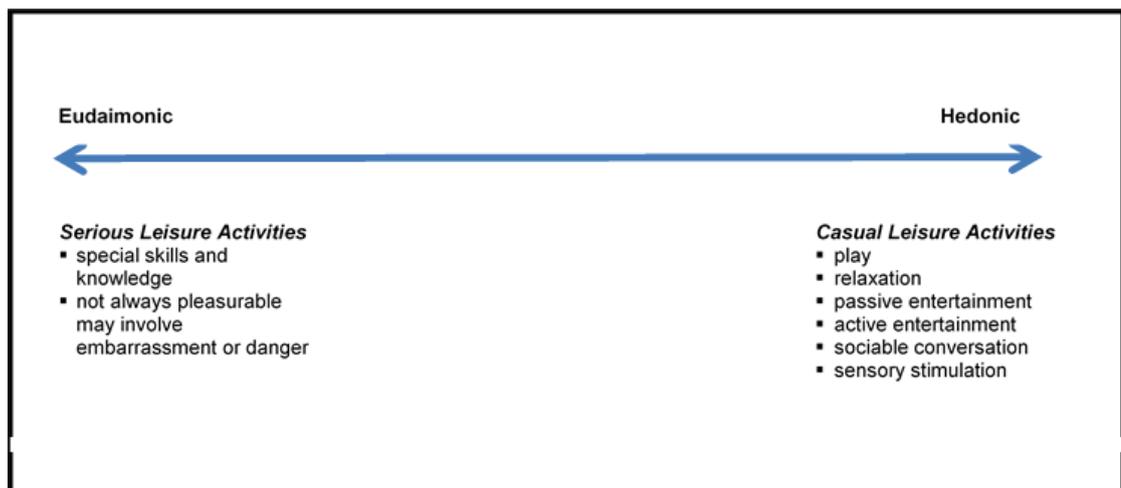


Figure 6: Serious and casual leisure activities mapped on a wellbeing continuum (Adapted from Voight et al. 2010)

While wellbeing research suggests that genetics accounts for approximately 50 percent and circumstance accounting for up to 15 percent of an individual's happiness (Lyubomirsky et al. 2005), the remaining percentage is comprised of intentional activity (Lyubomirsky et al. 2005), a context that is fundamental to tourism (Voigt et al. 2010). Waterman and colleagues (2008) maintain that there are two main categories of activities: those that promote only hedonic enjoyment and those that promote both hedonic enjoyment and eudaimonia. Interestingly, the activities that only lead to eudaimonic wellbeing are considered, within this context, to be within a theoretical null, due to the fact that activities which catalyse flow and personal expression are also hedonically enjoyed (Waterman 2005).

2.12 Tourism, wellbeing and the destination

Quality of life

Research evidence accepts the viewpoint that wellbeing (QoL) is more closely associated with eudaimonic experiences and activities (Ryan and Deci 2001). This raises concerns over the types of tourism experiences that are being provided, typically for hedonic pleasure, further only contributing to transient pleasure, not contributing to QoL or to eudaimonic experiences. Thus, it has been suggested, that to date, there is a very limited understanding of the connections that exist between tourism and quality of life/wellbeing (Moscardo 2009).

One recognised challenge, with quality of life research, is in the need to ensure that national and community level indicators are connected to individual level perceptions of wellbeing (Costanza et al. 2007). Research indicates that there is currently only a partial

understanding of the existing relationships between QoL and tourism (Moscardo 2009) and these emerge in the following sectors: slow tourism, adventure tourism, and volunteer tourism.

Slow tourism

Slow tourism can be viewed as being broadly positioned within the slow movement, advocates a return to a slower life when experience is savoured rather than modern industrial society's need to maximize consumption (Timms and Conway 2012). As a form of alternative tourism, slow tourism can be viewed to be linked to the concept of soft growth (Daly 1990) with the emphasis being on the advancement of development, quality, rather than that of the promotion of physical growth, quantity. Slow tourism offers a host of benefits which include the promotion of economic and social benefits to local communities and lessened environmental pressures. In terms of tourism demand, it is contended that there is an increasing demand for a more responsible form of tourism pursued by more consciously motivated tourists (Timms and Conway 2012).

Based on its philosophical roots, slow tourism represents the antithesis of mass tourism, a potential for socio-economic and environmental sustainability (Timms and Conway 2012). In terms of tourism product, slow tourism, offers one that is more sustainable, is more culturally sensitive, authentic and potentially offers a better-paced experience for both locals and tourists (Timms and Conway 2012). It is suggested that slow tourism offers an experience for tourists to enhance the quality of their lives through authentic enjoyment in a mutually enjoyable leisure environment for both locals and guests (Conway and Timms 2012).

Adventure tourism

While research is reported to be scarce, there are former studies which connect flow to a range of adventure tourism settings (Ryan 1997; Priest and Bunting 1993). Research has linked the flow experience to both activities and aesthetics (Pearce 2005). For example, De Botton (2002) illustrates tourists' reactions to extraordinary landscapes and cultural heritage sites.

The flow state, which is recognised as an intrinsically satisfying state (Csikszentmihalyi 1975), has been connected to tourist satisfaction. Filep (2007) contends that as flow, hedonia and eudaimonia are both connected to tourism, and may provide insights about travel encouraged wellbeing, derived from these approaches.

Volunteer tourism

Volunteer tourism is defined as a travel experience that is ideologically sound and contributes to the social, cultural, economic, and the natural environment (Wearing

2004). It is contended that volunteer tourism emerged at a time when consumers were looking for a more alternative form of travel experience (Wight 1993). There remains contention within tourism literature regarding volunteer tourists being altruistic (Coghlan and Fennel 2010; Matthews 2008), and their contribution to the social and natural wellbeing of the host environment (Callanan and Thomas 2005; McGhee 2001).

Coghlan and Fennell (2010) suggest that volunteer tourism may be distinguished from mass tourism through the application of the eudaimonic approach, that espouses that true happiness or wellbeing can be derived from doing what is worth doing and which leads to personal fulfillment and realisation of human potential. It is also contended that within volunteer tourism, hedonic experience is also sought. Mustonen (2005), however proposes that volunteer tourists have shifting roles where they may simultaneously seek out opportunities for, pleasure, relaxation, stimulation, shopping and partying.

Researchers contend that there is more research needed into volunteer tourism, as there remains much contention surrounding its viability as an alternative to mass tourism, and contributions to the destination and host community.

2.13 Conceptual framework

The review of extant literature in wellbeing, public health and tourism has revealed potential synergies embedded in theory and philosophy as depicted in Figure 7, the conceptual framework presents a summary of these synergies, which can be understood as public health seeking to promote a more holistic (salutogenic) form of wellbeing. In addition to tourist satisfaction and alternatives to mass tourism, presenting an opportunity to achieve similar wellbeing outcomes. Specifically, public health is theoretically linked to the eudaimonic and hedonic integrated wellbeing theory of flow (Csikszentmihalyi 1990) through the salutogenic, SOC scale (Antonovsky 1979).

Tourism research reveals a potential synergy between tourist experience and Seligman's (2002) authentic happiness theory. Filep and Deery (2010) connect anticipation, on-site, and reflection phases of the tourist experience to measurable evidence. This supports the wellbeing theory components of positive emotion, engagement and meaning. Additionally, Stebbin's (1997) conception of serious leisure highlights connections between potential tourism activities and flow theory.

While mass tourism is indicated as being almost entirely hedonic, slow tourism, adventure tourism and volunteer tourism offer alternative forms that may be classed as both eudaimonic and hedonic. Timms and Conway's (2012) conception of slow tourism reveals connections to eudaimonic wellbeing and a fit with the AHT. Also connected to AHT, volunteer tourism has been suggested to be embedded within the eudaimonic

approach, espousing true happiness leading to the realisation of human potential (Coghlan and Fennell 2010).

The main purpose of the conceptual framework within this study is to provide sensitivity to potential concepts that may emerge in data collection and analysis. This theoretical frame for synergising wellbeing, public health and tourism will offer a means to further triangulate from findings that ultimately serve to construct a theory explaining the phenomenon of intra-organisational strategic alliance development.

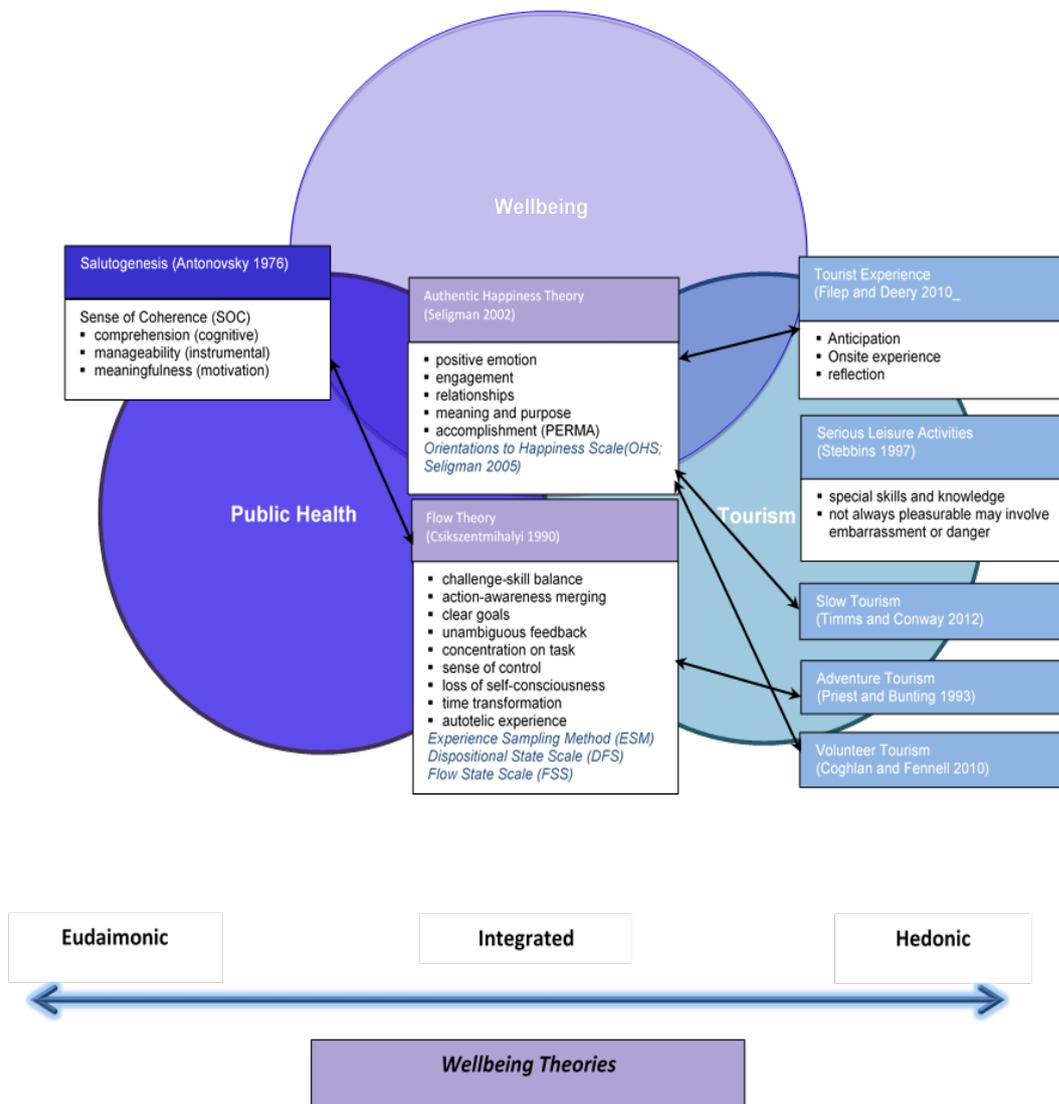


Figure 7: Mapping the potential synergies between wellbeing, public health and tourism

3. LITERATURE REVIEW: BOUNDARY OBJECTS & BOUNDARY MANAGEMENT

3.1 Introduction

This literature review chapter seeks to assess the concept of wellbeing as a potential boundary object to synergise public health and tourism communities of practice at the local level. The recent reorganisation of the UK public health agenda and repositioning of public health responsibility within the local government provides an opportunity to build this type of synergistic alliance. In the midst of this reorganisation and repositioning of the UK health agenda, the evaluation of boundaries, boundary objects and boundary crossing is timely in the consideration of future interdisciplinary collaborations.

This chapter will review the concepts of boundaries, boundary work, boundary objects and brokering. Next, the potential methods of convergence, or facilitation, of knowledge transfer and boundary crossing will be conceptualised to understand ways wellbeing may synergise public health and tourism communities of practice. To position this study within current theoretical constructs, the limitations of current theoretical approaches will be evaluated. The chapter will conclude with a section outlining the limitations of current theoretical frameworks, and the potential theoretical contributions of this study.

3.2 Boundary objects

It is suggested, that modern society depends on interdisciplinary workings, where functional teams within the public sector include members drawn from a range of knowledge, practice and skill sets. (Fox 2011). It is proposed that in interdisciplinary situations necessitating analysis and decision making, the challenge of boundary crossing is encountered (Slootweg et al. 2009). Research findings contend that there is a need for greater boundary crossing between disciplines (Rotmans 2003), further requiring a framework that can bridge philosophical, theoretical, and practical schools of thought from various diverse disciplines (Keshkamat et al. 2012). Increasingly, scholars put forward the notion that managing learning and innovation in multi-stakeholder network necessitates boundary work which could promote learning across boundaries and transform knowledge into innovation (Klerkx et al. 2012; Clark et al. 2011; Mollinga 2010). Further, it is contended that integrative processes involving participation, discourse and communication are necessary for the development of political strategies (Ingram and Endter-Wada 2009).

Past research exploring boundary object and boundary work have hypothesized the factors and strategies that promote successful boundary crossing (Clark et al. 2011). There remains a gap, however, in knowledge focusing on successful boundary strategies within specific settings (Clark et al. 2011). In the context of this study, it is proposed that

there may be opportunities and advantages of interdisciplinary collaboration within UK local authorities, particularly a strategic alliance between public health and tourism communities of practice.

Defining boundary objects

The concept of a boundary object was first proposed by Star and Griesemer (1989) to better understand types of interactions, when people from different communities collaborate on a common project or goal (Wilson and Herndl 2007). Star and Griesemer (1989) introduced the concept of boundary objects in their influential work focusing on the informational practices at the Museum of Vertebrate Zoology at the University of California, Berkeley. In the review of literature, the original conception of boundary objects is noted to be an important starting point to situate research problems or to justify points of departure. Star and Griesemer (1989) define the boundary object concept as:

An analytic concept of scientific objects which both inhabit several intersecting social worlds...and satisfy the informational requirements of each of them. Boundary objects are objects that are both plastic enough to adapt to local needs and the constraints of the several parties employing them, yet robust enough to maintain a common identity across sites. They are weakly structured in common use, and become strongly structured in individual-site use. These objects may be abstract or concrete (393)

As it was originally conceived within the body of social scientific knowledge, a boundary object is viewed as a tangible, physical object intervening between communities that can neither communicate nor understand one another (Star and Griesemer 1989; Wilson and Herndl 2007). Within this context, museum artefacts provided a general framework to coordinate actions of different actors. More recently, Star (2010) views boundary objects as a sort of arrangement allowing different organisations or groups to work collectively without consensus. Harvey and Chrisman (1998) claim that boundary objects establish a shared understanding through the moderation of differences, facilitating agreement along ontological and epistemological boundaries, further creating 'things' with increased validity to a greater portion of society. Boundary objects have additionally been described as translation mechanisms, where it is suggested that the maintenance of boundary objects is central to the development of coherence across different communities (Huvila 2011).

Since the original development of the concept of boundary objects, there have been definitional variations. For example, within the sphere of project management boundary objects are employed as a means of promoting and sharing knowledge between diverse groups (Yukura 2002; Brown and Duguid 2001). Bechky (2003) proposes that boundary objects are artefacts that are capable of both promoting and or suppressing knowledge sharing across boundaries.

More recently, boundary objects have been defined as entities that improve the capability of an idea, theory or practice to translate across boundaries between communities of knowledge or practice (Wenger 1998; Brown and Duguid 1991). The boundary concept is proposed to be a loose or vague concept, which is reported to be correlated to its cohesive power (Löwy 1992). Where research suggests that the vagueness of the concept allows communication and cooperation between members without having to give up their social identities (Allen 2009). Carlile (2002) contends that these objects play a coordinating role and can be as simple as a single word, facilitating activities, so called syntactic coordination which is the process of information transfer.

Within the context of this study, the boundary object of wellbeing is proposed as a means to understand potential shared understanding, knowledge, and strategies as applied to local public health and tourism communities of practice. The boundary object conceptualisation offers a means to bridge differences between diverse communities of practice through shared knowledge, goals and strategic direction.

Dimensions of boundary objects

Star and Griesemer (1989) originally identified three main dimensions of boundary objects: interpretive flexibility; the structure of different types of boundary objects; the aspect of scale/granularity (Star 2010; Star and Griesemer 1989). In terms of scale, it is noted that the boundary object concept is most useful at the organisational level (Star 2010) which is the intended scope of this study, the organisation being the local council.

Two of the prominent features identified among boundary objects are that they have an *interpretive scope* and *flexibility* (Spee and Jarabkowski 2009; Star and Griesemer 1989). Where a distinction of what makes boundary objects is in that they are meaningfully and usefully integrated into the work practice of actors in diverse fields (Star and Griesemer 1989). In terms of flexibility, Star and Griesemer (1989) advise that boundary objects ought to have a symbolic structure that is broad enough to be identifiable in more than one world. In this vein, it is contended that an object's flexibility is fundamental to the process of sense-making by different groups (Sapsed and Salter 2004; Henderson 1991).

Important aspects of Star and Griesemer's (1989) boundary object framework is the way that it is used as a metaphor for ecological systems, as opposed to being a top-down system, the epistemic authority within the framework, is broadly distributed. From an ecological viewpoint, there is not an epistemological primacy assuming that manager's epistemologies are neither better, nor worse than that of a programme coordinator. However, Star and Griesemer (1989) do concede that the boundary object remains biased towards the management figure. Waddell (1996) also supports this ecological

model which is described in the work of the Great Lakes Water Quality Board, as an example of a "two-way Jeffersonian model" of interaction where lay and expert knowledge is incorporated in equal weighting. Reviewed research, indicates that the allowance of a two-way flow of information and knowledge is both more successful at resolving conflicts and managing public policy (Wilson and Herndl 2007; Waddell 1996). An important aspect of Star and Griesemer's work and the contribution to successful border crossing is that the knowledge may be democratic, distributing epistemic authority across various communities of practice or knowledge (Wilson and Herndl 2007).

Breadth of use of boundary objects

The use of boundary objects has not been limited to natural sciences, where the conceptualisation first emerged, as it is suggested that expansion, monopolization, protection and autonomy are common features leading to their proliferation (Gieryn, 1983). Reviewed past research reveals that boundary objects have been utilised to understand a wide range of disciplinary inquiries, listed in Table 2.

DISCIPLINE/FOCUS AREA	RESEARCHER(S)
Accounting	Briers and Chua (2001)
IT	Kimble et al. (2010)
Organisational memory	Cacciatori (2003)
Education	Dirkinck-Holmfeld (2006)
Government	Guston (1999)
Health and social care	Sullivan and Williams (2012); Kimble et al. (2010)
Project management	Brown and Duguid (2001); Sapsed and Salter (2004)
Geography	Keshhamat et al. (2012)
Software engineering	Walenstein (2003)
Rural development	Tisenkopfs et al. (2014)
Sustainability	Metze (2017); Van Pelt et al. (2015); Benn and Martin (2010)

Table 2: Disciplinary range employing boundary object approach

Boundary object typology

Types of boundary objects are a useful consideration within the context of this study as a potential means of scoping and understanding the nuances associated with knowledge sharing between different communities of practice. In the originally proposed typology, boundary objects were described under four categories (Star and Griesemer 1989):

- (1) Repository indexed in a standard manner, facilitating access by members of different communities of knowledge or practice (i.e., a library or museum).
- (2) An ideal type, representation or abstraction that is robust enough to meet the needs of different communities, even though there is minimal detail, i.e., blueprint.
- (3) An object whose boundaries are the same for different communities, even if the bounded content varies, i.e., a map summarizing features of a landscape.
- (4) A standardized form which may be filled in by actors within different practice or knowledge communities.

This original taxonomy of boundary objects was not intended to be exclusive but, rather a general guide (Star 2010) and as such, has been modified since Star and Griesemer's original conception. For example, since the original development of the concept in 1989 other forms of boundary objects have been proposed: textbooks, performances, aspects of design and computer operating systems (Star 2010). As an example of type variations, Kimble and Hildreth (2005) propose that boundary objects are often technologies, and can also be drawings, sets of rules, research projects or documents.

One distinction that has been made in the literature is between facilitative and inhibitory boundary objects (Fox 2011). Examples of facilitative boundary objects include knowledge maps that can operate at a high level of abstraction describing entire systems, or at local levels, capturing particular knowledge and understanding of individual subgroups (Wilson and Herndl 2007). Many findings support the notion that boundary objects provide methodological symmetry further enabling cooperation (Wilson and Herndl 2007; Galison 1997; Fujimura 1992). Research findings posit that boundary objects are more facilitative when the communities of practice share a common syntax (Carlisle 2002) and common motives (Wilson and Herndl 2007).

Challenges and potential benefits of boundary object use

Challenges

Reviewed literatures outlines some of the challenges associated with using boundary objects. These include, that they are:

- Marginal nature, where some boundary objects may be more central than others (Sapsed and Salter 2004);
- Prone to overextension (Wilson and Herndl 2007);
- Ubiquitous, anything could be seen as a boundary object (Wilson and Herndl 2007);
- Lacking a clear definition (Wilson and Herndl 2007);
- Affected by changes to practice which may disrupt working agreement between communities thus, requiring negotiation (Sapsed and Salter 2004);
- May be more susceptible to neglect than others, as they are associated with more meaningful action and deemed less ambiguous (Sapsed and Salter 2004); and
- The basis for negotiations but do not necessarily provide a means to resolve differences (Yakura 2002).

While there are noted challenges to employing boundary objects as an approach to collaboration and knowledge sharing, the list of potential benefits to employing boundary objects are considerable.

Potential benefits

Many studies highlight the diverse range of potential benefits associated with employing boundary objects (Fox 2011; Van Edmond and Bal 2011; Spee and Jarzabkowski 2009). There are specific areas that may be enhanced through the utilisation of a boundary object namely: decision-making; understanding; coordination; and strategic outcomes.

Decision-making

- May reveal the need to exchange knowledge (Wilson and Herndl 2007);
- Can enable interaction and reveal boundaries within organisations (Spee and Jarzabkowski 2009);
- Could provide discursive space for negotiations to take place (VanEdmond and Bal 2011); and
- May contribute to the interpretation and translation of knowledge for policy and decision-making (Sismondo 1999; Morgan and Morrison 1999; Star and Griesemer 1989).

Understanding

- Can allow for the interpretation of different meanings by different groups (Henderson 1991);
- May provide learning opportunities (William and Wake 2007);
- May allow for collaborative action (Feldman et al. 2006);
- May provide a means to construct and communicate social identities (Gal et al. 2004);
- Offers the potential to draw on different ways of knowing to enhance common understanding (Brugnach and Ingram 2012);
- Can bridge perceptual and practical differences among communities (Lyytinen et al. 2001);
- May establish a shared language where knowledge and meaning can be shared (Carlile 2002);
- Enables working relationships around an idea, issue or innovative practice (Fox 2011);
- Allows for global and local demands while accommodating knowledge and language within the local context (Wilson and Herndl 2007);
- May provide a framework for understanding and accepting diverse disciplinary concerns in cross disciplinary exchanges (Wilson and Herndl 2007);
- May provide ways for individuals in different knowledge or practice communities to represent, question and transform their knowledge (Carlile 2002);
- Boundary objects/organisations may perform like services across communities of practice or organisational boundaries (Berkes 2009; Guston 2001; Jasonoff 1990).

Coordination

Research findings suggest that boundary objects are a means to both mitigate conflict and promote coordination, where they have been offered as:

- A remedy to balkanization (Sapsed and Salter 2004);
- A way to promote integration and understanding versus contest, controversy and segregation (Wilson and Hendl 2007);
- A means to bring peace to a conflictual situation (Fox 2011).

Strategic outcomes

Much research evidence has supported the role of boundary objects in the creation of enhanced strategic or policy outcomes. Empirical evidence suggests that boundary objects:

- Act as forums and policy instruments which cross group boundaries and promote integrative deliberation (Legano and Ingram 2009);
- Play a role in the creation of hybrid strategies, policies and or outcomes (Bal et al. 2002);
- Provide a motive and method for embracing epistemic symmetry (Wilson and Herndl 2007); and
- Cross barriers and facilitate knowledge growth or policy success (Fox 2011).

While there are several noted benefits to utilising a boundary object to synergise communities or entities, it is paramount to explore the variables associated with boundaries, knowledge types, brokering mechanisms and the roles of brokers.

3.3 Boundaries

Defining boundaries

It is proposed that a key ingredient of competitive advantage is working across boundaries between disciplines, as this is where innovation is proposed to happen (Leonard 1995). A boundary can be viewed as a socio-cultural distinction which leads to patterns of action or inaction (Akkerman and Bakker 2011). Where many studies treat boundaries as markers of difference, Star (2010) and her collaborators view boundaries as an interface that may facilitate knowledge production (Lamont and Molnár 2002). This conception of boundaries is important as it highlights that boundaries do not merely function as a means of exclusion and separation, but may also function as a device for bridging, exchange, communication, and potential inclusion (Bryson 1996; Peterson and Kern 1996).

Conceptual domains

Boundaries are notably increasing with greater specialisation, thus there is a search for ways to connect across social and cultural practice in an effort to avoid balkanization (Hermans & Hermans-Konopka 2010). A review of literature highlights that boundaries or borders are discussed in a diverse range of social sciences debating how symbols of difference are generated, maintained, or challenged at several levels (Lamont and Molnár 2002).

As a precursor to developing a framework for understanding boundaries Carlile and Robertisch (2003), outline the three properties of knowledge at a boundary: difference, dependence and novelty. Difference refers to the amount and type of diversified knowledge that is required to create innovation. Where knowledge is framed as an investment requiring time and resources in its acquisition thus, there are costs involved in giving it up and obtaining new and different knowledge (Carlile 2002). As the next relational property of knowledge, dependence is defined as a condition where two units must consider each other if they are to meet their goals (Litwak and Hylton 1962). Where, it is suggested that the actions of community actors are related to goals of actors that depend on one another (Victor and Blackburn 1987). The third relational property of knowledge at a boundary is related to how novel situations appear (Carlile 2002). The main significance noted around novelty is when it is present, the capacity of the knowledge and the ability of the actors to use it becomes a salient issue.

Akkerman and Bakker (2011) contend that all learning involves boundaries (Lave and Wenger 1991) and describe four possible learning mechanisms which can take place at boundaries: identification, coordination, reflection, and transformation. Research reveals that these mechanisms can function as tools for the development of interconnecting identities and practices (Akkerman and Bakker 2011). Boundaries are noted to become more rigid when they are embedded in discursive, social and material routine (Halffman 2003). It is proposed that boundaries between different disciplines or organisations are both explicit and systematic (Halpern 2012). While boundaries are constructed within their related networks, they are dynamic. In order to achieve success, it is suggested that boundaries will need to be crossed between three main domains: research (by credibility), policy (with salience) and society (through legitimacy) (Keshamat et al. 2012).

Types of boundaries

Boundary objects are suggested to take the forms of representations, abstractions or metaphors which resonate with different communities of practice (Arias and Fischer 2000; Star and Griesemer 1989). Knowledge boundaries have been noted to be both a source of, and a barrier to, innovation (Carlile 2002). There are three knowledge boundaries proposed within recent literature which present varying levels of challenge to sharing knowledge, namely: syntactic, semantic and pragmatic boundaries (Carlile, 2002, 2004).

From this perspective, *syntactic* boundaries are seen as being the simplest under the assumption that knowledge is transferred between actors as there is a common syntax. A *semantic* boundary is recognised as being more complex as common meanings are something that still need to be developed in order to translate knowledge, for example between different departments. *Pragmatic* boundaries are recognised as having the

greatest social and political complexity – where mutual interests still need to be developed to ‘transform’ knowledge at the pragmatic boundary (Carlile 2004). Studies support the notion that boundary objects promote the transfer, translation and transformation of knowledge across semantic and pragmatic boundaries (Carlile, 2002, 2004).

Despite the boundaries that are often established within disciplines, organisations and professionals in different fields, there are cases where it may be a requirement to work across boundaries (Halpern 2012). In the case of public health and tourism it is proposed, within this study, that crossing boundaries between these disciplines and organisations may be mutually beneficial in order to best address a local wellbeing agenda. Additionally, according to the barrier typology defined by Carlile (2002, 2004), the types of boundary to be crossed in the context of public health and tourism could be identified as either semantic or pragmatic which are viewed to be more complex boundaries to cross, yet still evidenced to be possible (Carlile 2002, 2004).

3.4 Communities of practice

In considering tourism and public health, one could argue that there are two distinct communities of practice within the local authority. The communities of practice are twofold understood as both an approach and a theory, where the limitations of the theory are identified later within this chapter. Lave (1991) is credited with the first introduction of the term community of practice (Kimble and Hildreth 2005). The term was later used by Lave and Wenger (1991), whereby a community of practice was described as a set of interactions among people, activity and world with other overlapping communities of practice. The concept was originally developed around an apprenticeship and the learning that occurred in practice, language, and conventions which lead to the apprentice ultimately becoming a legitimate member of the community (Lave and Wenger 1991).

A community of practice is viewed as an informal group of individuals connected in common endeavour (Pawlowski et al. 2000). It is typified by the manner by which the members act and how they interpret actions. Wenger (1998) describes practice as that which provides coherence for a community and includes explicit language, tools, documents, images, symbols, procedures and various practices. It is also noted to include tacit perceptions, conventions, subtle cues, underlying assumptions and shared world views (Wenger 1998).

Communities of practice are generally informal structures, and are reported to emerge from engagement in practice (Pawlowski et al. 2000) where interdependent participants construct the social context for shared identities to be formed (Brown and Duguid 2001).

Wenger (1998) advises that boundaries of communities are not consistent with the boundaries of more formal organisational structures (Wenger 1998). It is suggested that an organisation may be seen as a collection of communities of practice, with each community having its own developed perspective or worldview (Brown and Duguid 1991).

Communities of practice (Brown and Duguid 1991, 2001; Lave and Wenger 1991; Lave 1991) are described as informal work-based organisations. It is contended that in the formal development of practice, there is the creation of epistemic differences between these communities (Sapsed and Salter 2004). In these situations, it is argued that successful knowledge transfer is to be difficult as there is a lack of shared work and social context (Sapsed and Salter 2004).

Research findings suggest changes to practice affecting the boundary object would interrupt the agreement between communities thus requiring negotiation between them (Sapsed and Salter 2004). This change in a community's practice is referred to by Brown and Duguid (2001) as a form of dynamic organisational coordination. To date, the main link between boundary objects and communities of practice has been forged by Wenger (1998) who uses the notion of boundary objects in order to describe the role of shared artefacts in communities of practice (Kimble and Hildreth 2005), where boundary objects are reported to create reificative connections between communities of practice (Wenger 1998).

3.5 Boundary management

Boundary management learning

Boundary objects, residing at the interface between communities are proposed to be capable of bridging both real and perceived differences, yet, it is emphasised that bridging may neither be a neutral or consensual activity (Huvila 2011). Kimble and colleagues (2010), affirm that the challenges associated with cross-boundary knowledge sharing are paradoxically what may make it of value. One of the noted challenges to knowledge sharing arguably rests upon whether or not there is a shared worldview (Clark and Brennan 1991). Research findings also identify that the more radical the innovation, the greater the potential problems in negotiating power across boundaries (Christensen et al. 2000).

Many researchers posit that co-located work groups tend to better share knowledge than dispersed group members (Scarborough et al. 2004; Kiesler and Cummings 2002). Co-location is identified as being significant to project team members' knowledge integration

(Galegher et al. 1990). The review of the literature addressing knowledge sharing reveals there is an inclination for knowledge to be locally entrenched and challenging to transfer over any distance (Sapsed and Salter 2004). Research findings propose that people working in separated teams, more commonly disengage or 'drop' members who are distant (Mortenson and Hinds 2002). This challenge of being 'out of sight, and out of mind', also triggered lower effort and greater free riding, further leading to work delays (Kiesler and Cummings 2002).

The importance of face-to-face interaction is fundamental to facilitating the transfer of complex knowledge as well as building trust, commitment and social capital (Sapsed and Salter 2004). Storper and Venables (2003) profess that face-to-face interaction increases heart rates, arouses performance instincts, and people will work harder to connect and empathize with co-workers. Findings also suggest that eye-to-eye contact holds attention, and the act of physical touch like a handshake or embrace may construct social bonds (Nardi and Whittaker 2002). Similarly, it is further proposed that where there is not an opportunity for face-to-face interaction, relationships tend to falter (Sapsed and Salter 2004).

Akerman and Bakker (2011) assert all learning that takes place involves boundaries. Cash et al. (2003) suggest that boundary management necessitates three primary activities - communication, translation, and mediation crossing boundaries between organisations and stakeholders. In some cases it is noted that boundary work is institutionalised into an official boundary organisation (Legano and Ingram 2009). Where findings indicate boundary organisations involve three significant features: (i) the creation of special roles within the organisation for boundary management; (ii) formally allocating roles among participants across the boundary, and (iii) providing a forum where information can be coproduced by various actors utilising boundary objects (Cash et al. 2003).

The creation of new knowledge is dependent on both communication and the development of new findings. One of the main challenges when actors from different organisational worlds interact is the different meanings ascribed to new objects (Carlile 2002). Thus, the primary challenge faced is to reconcile these meanings. Another noted challenge is that these 'so called worlds' can have both commonalities and differences (Star and Griesemer 1989).

Convergence

The concept of convergence describes a process whereby different social worlds or communities of practice come together, in a process of mutual constitution (Star et al. 1997). The concept of convergence was originally developed to describe the process

that information artefacts and social worlds intermingle, a process referred to as mutual constitution (Star et al. 1997). Conversely, divergence is perceived as the movement away from working together, a move towards incompatibility (Pawlowsky et al. 2000). Boundary object brokering is often the label given to activities and processes aimed at successful convergence of boundary objects with the communities of practice that they bond (Pawlowsky 2000).

Boundary crossing typically refers to transitions and interactions across different communities of practice or sites (Suchman 1994). Boundary crossing is suggested to be a vast and under-studied type of cognitive process (Engeström et al. 1995). Star and Griesemer (1989) propose a boundary object model highlighting the role of translation in determining the boundary object that would optimise both autonomy and communication between worlds. The determination of the potential of convergence is related to the primary aims of this research. Boundary object brokering is seen as the label ascribed to activities and processes striving towards the convergence of a boundary object, wellbeing, with the communities of practice that they connect namely health and tourism.

Brokering

Brokering is contended to provide a link between communities of practice (Pawlowsky et al. 2000). Activities in brokering are suggested to facilitate transactions and knowledge flow between communities of practice (Pawlowsky et al. 2000). Wenger (1998) proposes that the process of brokering requires sufficient legitimacy to sway practice development, and address conflicting interests. It is advised that brokers themselves be able to build new connections across communities of practice, and enable avenues for meaning (Wenger 1998).

It is proposed that there are four mechanisms involved in brokering or border crossing namely: identification; coordination; reflection; and transformation. Where different disciplines need to cooperate and information must travel across borders of diverse communities yet retain integrity, a fundamental question becomes, how can two communities with two differing, potentially irreconcilable epistemologies cooperate (Wilson and Herndl 2007; Fujimura 1992)?

Wenger (1998) identifies three types of brokering processes - translation, coordination, and alignment. Here *translation* is defined as a process of framing, which aligns the worldview of one community to a different community. *Coordination* is referred to as a process of bringing together perspectives whereby communities of practice avoid working antagonistically. *Alignment* is the process of relating an endeavour from a community of practice to a greater context of meaning (Pawlowski et al. 2000).

Brokers

The concept of brokers (Wenger 1998), offers a possible route for epistemically distinct groups to communicate (Kimble et al. 2010). Brokers are defined as members of several communities who can effectively make connections between them, coordinating new areas for learning and exchange (Brown and Duguid 1998). Carlile (2004) suggests that a broker's role is to assist other people to transfer, translate and transform meanings during collaborative activities.

The people that exist at the boundary are referred to as brokers, boundary crossers or boundary workers (Akkerman and Bakker 2011). These individuals or groups of people are the ones that actually encounter irregularities in both their actions and interactions, thus it is suggested that brokers are worthwhile as a point of analysis to better understand boundaries (Akkerman and Baker 2011). It is reported that brokers have the task of building bridges and connecting sides, however, while accountable to each community, criticism is endured for being either too aligned, or too abstract to align (Fisher and Atkinson-Grosjean 2002). Tangaard (2007) describes the position at the boundary as being marginal strangers, not really belonging. Akkerman and Bakker (2011) report that research findings reveal how brokers are simultaneously a bridge and divisive force. Star and Griesemer (1989) refer to brokers as being a means of translation within a situation of multiple relations and requirements.

In the context of leadership it is proposed that some leaders tend to be successful due to their boundary-crossing leadership style (Morse 2010). Where there are strong advocates for the promotion of boundary crossing competence that would include an ability to effectively manage diverse discourses and practices across boundaries (Fortuin and Bush 2010; Walker and Nocon 2007). It is contended that brokering requires the ability to simultaneously manage membership and non-membership, where there is sufficient distance to remain objective, and adequate legitimacy to be heard (Wenger 1998).

As a means of mitigating brokering conflict, the concept of trading zones was introduced by Galison (1997) in order to preserve the differences between groups or subcultures and account for the history of their cooperation. Trading zones are defined as formations of distinct groups, with different goals and backgrounds that cooperate in a specific action. It is suggested that the knowledge map is fundamental to Galison's (1997) trading zone (Wilson and Herndl 2007).

Knowledge transfer

While there is a growing body of research on organisational knowledge transfer, there still remains a lack of clarity around its antecedents (van Wijk et al. 2008). Research findings support the notion that the ability to transfer knowledge will improve an

organisation's performance (Epple et al. 1996; Galbraith 1990) and provide a basis for competitive advantage (Tsai 2001; Zahra 2000). There is also mounting evidence supporting the notion that internal knowledge transfer between organisational groups offers competitive benefits (Schulz 2001; Gupta and Govindarajan 2000). Similarly, Nonaka (1994) proposes that knowledge-creating activities can also lead to greater innovation. While the benefits of knowledge transfer are well documented, its effectiveness is suggested to vary amongst different organisations (Argote 1999; Szulanski 1996).

In defining knowledge transfer, researchers distinguish between individual and organisation levels. At the individual level, knowledge transfer refers to how knowledge attained in one situation applies to another (Singley and Anderson 1989). At an organizational level, Argote and Ingram (2000) define knowledge transfer as the process by which one group is affected by the experience of another. While it is contended that knowledge transfer at the organisational level also involves transfer at the individual level, the challenge of transfer at organisational levels are noted to transcend the complexity at the individual level (Argote and Ingram 2000).

Argote and Ingram (2000) suggest that knowledge transfer happens when experience in one part of an organisation affects another part and can be either implicit or explicit. It is proposed that knowledge transfer is revealed through changes, and thus can be measured by measuring changes in knowledge or performance (Baum and Ingram 1998). It is suggested that a large amount of organisational knowledge acquired may be tacit and thus not simply articulated (Nonaka 1991). Thus, this type of knowledge transfer may be difficult to measure as it would not be captured in verbal reports (Argote and Ingram 2000). Accordingly, performance-based measurements have been suggested to measure knowledge more directly (Berry and Broadbent 1984, 1987).

It is suggested that a primary challenge to measuring knowledge transfer within groups is that it may exist within several repositories (Levitt and March 1988; Starbuck 1992; Walsh and Ungson 1991). Types of repositories for knowledge within organisations include: individual members; roles and organizational structures; the organization's standard operating procedures and practices; its culture; and the physical structure of the workplace (Walsh and Ungson 1991). Thus, to measure change in knowledge, it must be captured within each of these repositories. These repositories arguably have an important dual function in that they change when transfer happens and therefore, the changes within the knowledge repositories are indicators of the outcomes of the knowledge transfer (Argote and Ingram 2000).

McGrath and Argote (2001) propose a framework whereby knowledge is rooted in three basic elements within organisations namely members, tools and tasks (Argote and

McGrath 1993; Arrow and McGrath and Berdahl 2000). Within this context, members refer to the human mechanisms within the organisation. Tools are the technological component and include the hardware and software. Tasks are reflective of the organisation's intentions, purposes and goals. Where it is suggested that in the case of knowledge, if it remains as a mere repository of information, the organisation is arguably not using it to learn (Goh 2002).

It is generally accepted among knowledge researchers that there are two main types - explicit knowledge, which can be codified and tacit knowledge that can be difficult to articulate (Nonaka 1994; Havens and Knapp 1998). Research indicates that a salient challenge in knowledge management is defining how knowledge types can both be codified and transferred within an organisation (Goh 2002). Past study findings indicate that codified knowledge transfers with greater ease than that which is not codified (Argote and Ingram 2000).

While knowledge type and codification act as determinants of knowledge transfer, there are several additional factors that are linked to the transfer of knowledge. Where factors positively affecting knowledge transfer include:

- Strategic similarity positively affected (Darr and Kertberg 2000)
- Characteristics of the social network affect extent (McEvily and Zaheer 1999)
- The nature of social ties interacts with the type of knowledge being transferred thus affecting transfer outcomes (Hansen 1999)
- Characteristics of the task where the greater the similarity, the greater the likelihood of transfer (Darr and Kurtzberg 2000; Singley and Anderson 1989)
- Characteristics of the tools being transferred – simple technology, geographic closeness (Galbraith 1990)
- Leadership practices and behaviours a major factor in the success of knowledge sharing (Goh 2002)
- Cultural dimensions of cooperation and collaboration critical to transfer (Goh 2002)
- High level of trust an essential condition for willingness to cooperate (Levin and Cross 2004)

In the evaluation of potential determinants of synergies between public health and tourism communities of practice, the reviewed knowledge transfer body of knowledge, contributes to the conceptual understanding within this study. Empirical evidence centering on knowledge transfer to date has not linked boundary objects to knowledge sharing, transfer or exchange (Goh 2002; Argote and Ingram 2000). In the scant knowledge transfer literature that does make mention of the concept of boundaries, the language and frame employed differ from that of researchers grounding their work in Star and Griesemer's (1989) early work. In the review of knowledge management literature, it is suggested that studies have been mainly exploratory, lacking a central theoretical framework (Watson and Hewett 2006). That said, the knowledge transfer

literature reviewed, provides additional concepts to consider in the potential synergistic alliance of communities of practice within an organisation.

Conceptual map

As a means to conceptually map the current literature on boundary object management and knowledge transfer, Figure 8 highlights the main determinants of boundary crossing and knowledge transfer within the context of potential synergies between public health, tourism and wellbeing (boundary object) with the local authority. The

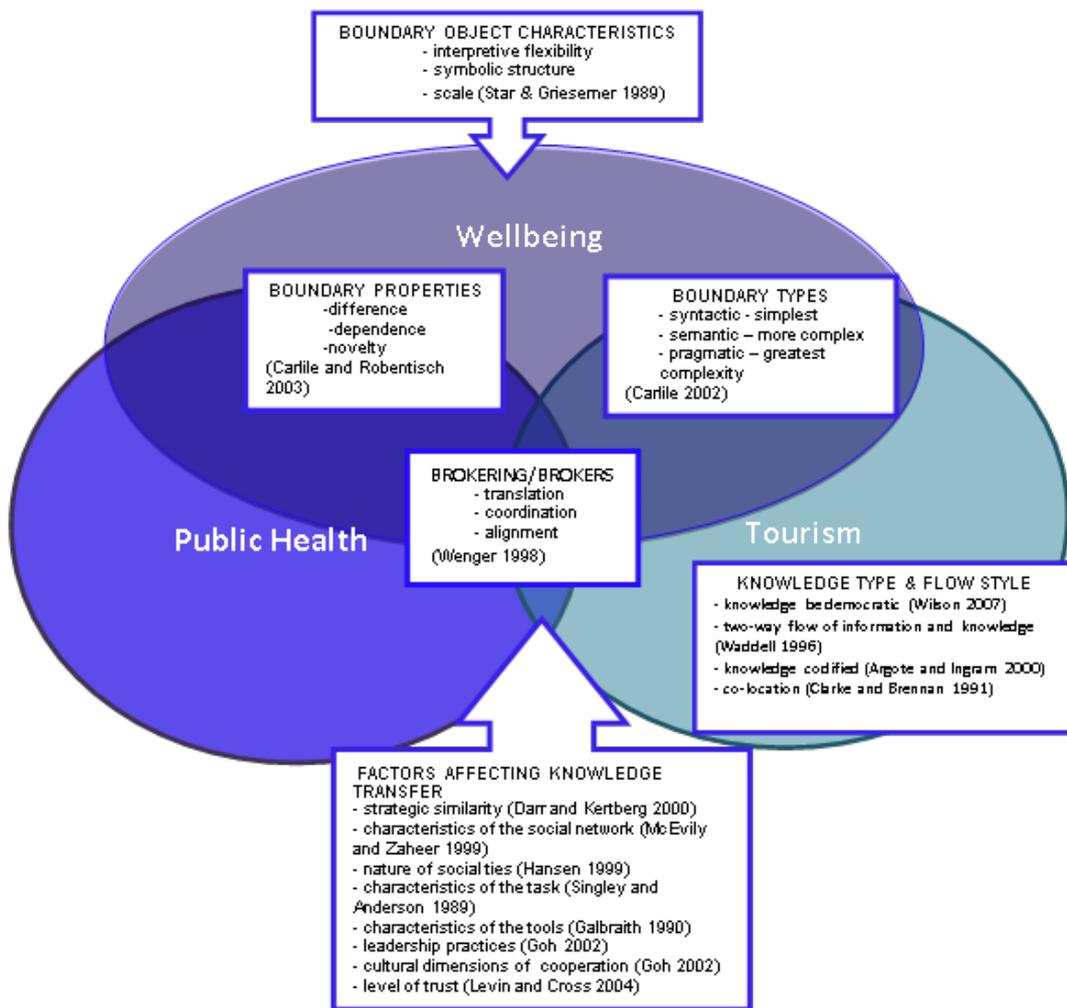


Figure 8: Potential determinants of boundary crossing and knowledge transfer

Characteristics of the boundary object that include the interpretive flexibility, symbolic structure and scale (Star and Griesemer 1989), are proposed to influence the success of knowledge being transferred between community of practice. In the context of this study, the concept of wellbeing is suggested to be a boundary object that enables

knowledge transfer between public health and tourism departments within the local authority. Carlile (2002) suggests that knowledge boundaries can have a range in their levels of complexity and are either: syntactic, semantic or pragmatic. Within this study it is put forward that the type of knowledge boundary that needs to be crossed between public health and tourism departments is pragmatic, where mutual interests still need to be developed to 'transform' knowledge at the boundary. The pragmatic boundary is viewed to be a more complex boundary to cross, yet is still evidenced to be possible (Carlile 2002;2004). Additionally, relational properties of the knowledge at the boundary include difference, dependence and novelty. In the case of the concept of wellbeing, it may be referred to as a novel situation, which could influence the likelihood of knowledge crossing boundaries.

Other factors depicted in Figure 8, that may influence knowledge transfer between communities of practice include: that knowledge is democratic (Wilson 2007), that there is a two-way flow of information (Waddell 1996), that knowledge is codified (Argote and Ingram 2000), and that team members are co-located (Clarke and Brennan 1991). Additional factors that may affect knowledge transfer are related to: the strategic similarity (Darr and Kertberg 2000), social network characteristics (McEvily and Zaheer 1999), the nature of the social ties (Hansen 1999), the characteristics of the task (Singley and Anderson 1989) and characteristics of the tools employed (Galbraith 1990), leadership practices (Goh 2002), the cultural dimensions associated with cooperation (Goh 2002), and the levels of trust (Levin and Cross 2004).

The role of brokering is another factor to consider in the transfer of knowledge between communities of practice. Wenger (1998) outlines three types of brokering processes: translation, coordination, and alignment, highlighting the significant role of brokering that occurs at the boundaries existing between communities. Collectively, these potential factors affecting knowledge transfer provide a conceptual framework to sensitise the researcher in the process of data collection and analysis.

3.6 Evaluation of current theoretical constructs

Actor network theory

The actor-network theory (ANT) is an approach that was originally proposed by scholars which include Latour, Callon and Law. While, it is referred to as a theory within much of the literature reviewed, Law (2004) contends that actor-network is an approach and not a theory as it is descriptive rather than explanatory.

The actor-network contends that the world is filled with hybrid entities (Latour 1993) comprised of both human and non-human elements, where ANT was developed to

evaluate cases where separation of these elements is problematic (Callon 1997). Thus, in studies focusing on the socio-technical divide ANT is a framework that dismisses the existence of purely technical or purely social relations (Tatnall and Gilding 1999). The issue of anti-essentialism is a main contention of ANT, and is what distinguishes the approach from others (Latour et al. 1992). The actor network theory does not distinguish between social and technological but rather the network effects (Tatnall and Gilding 1999). Where social or technical determinism is viewed as being flawed, a socio-technical approach is utilised (Latour 1986; Law and Callon 1988).

The actor-network theory has been referred to as the 'sociology of translations' (Callon 1986b; Law 1992) is interested in the mechanics of power that is constructed and maintained through networks (Tatnall and Gilding 1999). Within the context of this PhD research project, it is not appropriate as it is more descriptive, and the main aim of the research is to determine the specific engagement experiences within communities of practice that catalyse knowledge transfer or transformation. Secondly, the ANT is more concerned with the relations between the human and non-human or technical worlds, which in this case are less relevant, as the proposed boundary object is wellbeing which is an idea, concept or theory and the focus is on the human interactions facilitating knowledge transfer.

Community of practice theory (CoP)

Boundary objects are a component within community of practice theory and include artifacts, documents, terms, and concepts around which communities of practice may arrange their interconnections. Boundary objects within the context of community of practice theory may allow coordination without constructing a bridge between the meanings held by various communities (Wenger 1998).

Again, within this specific research project, this theory does not seem a good fit, as one of the primary aims is to determine whether the concept of wellbeing may be a bridge for synergies, in knowledge and strategy, between public health and tourism and CoP theory does not adequately address aspects inherent to building alliances.

Ways of knowing theory (WoK)

A Way of Knowing (WoK) is described by Ingram and Schneider (2007) as how a person interprets fundamentals and makes sense of related associations within a policy sphere. It is referred to as a narrative which cohesively binds parts together. It is described as a concept embracing various alternative political motivations and analysis modes (Schneider 2007). Ways of knowing approach is referred to as a process theory as it centres its attentions on the process of meaning construction. Ways of knowing differs

from the theory of boundary objects/boundary maintenance in that interaction between ways of knowing may blur boundaries (Legano and Schneider 2009).

The elements within the policy space include people, objects, ideas and relationships and their inter-relationships (Schneider 2007). It builds on the actor network theory and the notion that things within a policy space have agency as humans do (Schneider 2007). Schneider (2007) posits a way of knowing needs to be focused on an issue or problem within the policy sphere, where, a way of knowing cannot exist without the issue being recognised. In this study, the particular issue or conflict is unknown thus it too does not seem to be a correct frame for understanding knowledge sharing tensions. Additionally, ways of knowing tends to apply to policy in general, conversely within this project; the primary focus is on the potential for a strategic alliance, which would be a precursor to policy negotiations.

Boundary object approach

In terms of the boundary object approach or theory, the literature review reveals a number of current limitations. Fox (2011) recognises that to date, the boundary object approach has been mainly taxonomic and descriptive. The majority of research effort post Star and Greisemer has focused on classifications and taxonomy thus, the concept remains under-theorised. Similarly, Pawlowski and Robey (2000), note that theory remains limited in regards to brokering processes among communities of practice. In absence of an explanatory component, Legano and Ingram (2009) contend that the boundary object approach does little to explain successful components of each policy endeavor, where it is argued boundary objects are merely structural entities that, when imposed across communities of practice will not deliver sustainable change. Pawlowski and Robey (2000) additionally observe that there is scant research focused on either the impacts of brokering on convergence or outcomes of brokering activities.

3.7 Conclusion

In this review of literature, there has not, to date, been any research connecting boundary objects to local strategic level planning, integrating wellbeing, public health and tourism. This chapter has reviewed the literature related to boundaries, brokering, communities of practice, and knowledge transfer to evaluate current theoretical approaches, in order to frame the concept of wellbeing, as a potential object synergising public health and tourism at the local level. Potential convergence methods have been identified through brokering mechanisms of identification, coordination, reflection, and transformation (Wilson and Herndl 2007; Fujimura 1992). Additionally, three types of brokering processes have been identified: translation, coordination and alignment (Wenger 1998), with the process facilitated by brokers engaging in a role to transfer, translate and

transform meanings during collaborative activities (Carlile 2004). Collectively, these mechanisms, processes and roles serve as a conceptual framework for understanding how wellbeing as a boundary object may potentially mediate knowledge across public health and tourism boundaries.

In the review of literature on boundaries and boundary objects, there is a noted gap in theory, where the current boundary theory approach remains descriptive and taxonomic. This study therefore seeks to contribute to addressing current theoretical gaps particularly focused on the role and outcomes of brokering within engagement processes. Additionally, this research seeks to build a theoretical foundation from which to better understand the mechanisms involved in facilitating boundary crossing between wellbeing, public health and tourism. The next section will outline how the research inquiry, which addresses the knowledge gaps identified in the review of literature, is best addressed through the adoption of the constructivist grounded theory methodology as the philosophical and methodological framework.

4. PHILOSOPHICAL AND METHODOLOGICAL FRAMEWORK

4.1 Introduction

The preceding chapters reviewed the literature on wellbeing, public health, tourism, and destination management (Chapter 2); and boundary objects, boundaries, brokering and knowledge sharing (Chapter 3) which revealed that there been few examples in the literature which connected wellbeing, public health and tourism at the local level. The review of literature illustrated the theoretical gap in knowledge focused on how public health and tourism communities of practice could be synergised through the construct of wellbeing at the local destination level. From a methodological perspective, the review of past research connecting wellbeing and tourism and highlighted that there were very few studies that used a grounded theory style of methodology to understand boundary object use and management. The majority of past research focused on methods of market analysis using surveys (Mueller and Nahrstedt 2004; Kaufmann 2000), multidisciplinary concept analysis (Sheldon and Bushnell 2009), case study/ policy analysis (Mair 2005) or were exploratory in nature seeking to build definitional frameworks around wellbeing and wellness (Voight et al. 2011). Currently, there has not been research connecting wellbeing, public health and tourism that explores grounded theory methodology to better understand the antecedents of interdepartmental synergies.

This chapter seeks to outline the rationale for adopting the constructivist grounded theory methodology as the study's philosophical and methodological framework. The primary rationale for the selection of the constructivist methodological approach is that it provides the best fit for addressing the study's main research inquiry, to evaluate the social processes that contribute to a synergistic relationship between wellbeing, public health and tourism. The approach is based on the assumption that a synergistic or collaborative relationship is a social process. Constructivist grounded theory methodology has also been selected as there is a theoretical gap in explaining how wellbeing, public health and tourism may be synergised, where grounded theory methodology provides an approach to develop an explanatory substantive theory. Research suggests that a robust research design begins with choosing a research paradigm that reflects the researcher's beliefs about the nature of reality (Mills et al. 2006). The selection of the constructivist grounded theory methodological approach is also aligned with the researcher's constructivist philosophical stance which acknowledges the relativism of numerous social realities and the co-creation of knowledge by researcher and participant, where meanings are both plural and context-dependent.

This chapter will locate the study’s aims and research questions within the constructivist paradigm, relativist ontology, constructionist epistemology, the symbolic interactionist perspective and a constructivist methodological approach. The chapter seeks to critically examine alternative research approaches to further provide justification for the selection of constructivist grounded theory. The historical roots, debates, and strands of grounded theory will be examined to illustrate how constructivist grounded theory methodology offers the best ‘fit for purpose’ approach to successfully achieve the study’s aims.

4.2 Qualitative versus quantitative research approaches

In order to best address the study’s research question, qualitative research approaches will be employed to understand social processes and interactions which may catalyse synergies between intra-organisational communities of practice as bridged through the boundary object of wellbeing. Qualitative research is an appropriate choice, as it focuses on understanding issues from the perspective of the participants, to better understand ascribed meanings to action, objects or events (Hennick et al. 2011). Further, it is contended that the qualitative approach allows for a more detailed examination of human experience, through the use of specific methods, such as interviews (Hennick et al. 2011). From this perspective, this study, seeks to understand participants within the context of their work environments, with the researcher endeavouring to interpret phenomena as individuals construct meaning (Guba and Lincoln 2005).

	Qualitative research	Quantitative research
Objective	To gain a detailed understanding of underlying reasons, beliefs, motivations	To quantify data and extrapolate results to a broader population
Purpose	To understand why? How? What is the process? What are the influences or contexts?	To measure, count, quantify a problem. How much? How often? What proportion? Relationships in data?
Data	Data are words (called textual data)	Data are numbers or numerical data
Study population	Small number of participants or interviewees, selected purposively (non-randomly) Referred to as participants or interviewees	Large sample size of representative cases Referred to as respondents or subjects
Data collection Methods	In-depth interviews, observation, group discussions	Population surveys, opinion polls, exit interviews
Analysis	Analysis is interpretive	Analysis is statistical
Outcome	To develop an initial understanding, to identify and explain behaviour, beliefs or actions	To identify prevalence, averages and patterns in data. To generalize to a broader population

Table 3: Contrasting qualitative and quantitative research (Hennink et al. 2011)

Qualitative research has been described as a situated activity which locates the observer within the world (Paton 2002). As depicted in Table 3, qualitative and quantitative

research approaches are contrasted, where the figure outlines the main elements that are embedded within qualitative approaches. Where quantitative research seeks to count, measure, and quantify problems through the analysis of large numerical data sets, qualitative research aims to understand processes through related influences and contexts through textual data which are derived from a small number of participants or interviewees that are purposively selected (Hennink et al. 2011). This study seeks to understand social processes involved in promoting collaboration between the wellbeing concept and public health and tourism departments within the local council. The study is guided by the aim of evaluating how these three entities may be synergised and examining the associated influences and contexts. As is the tradition of qualitative research, this study utilises data collection methods of observation and interviews rather than surveys, where the analysis is more interpretive as opposed to statistical. Within this grounded theory study, the intended outcome of the qualitative research is to gain a better understanding of behaviours, beliefs and actions in greater depth versus breadth (Hennink et al. 2011).

4.3 Considering alternative qualitative methodologies

Ethnography

The ethnographic methodological approach is rooted in cultural anthropology and is concerned with the nature, construction and preservation of culture (Goulding 2004; Savage 2000). Ethnographies aim to look beyond the spoken word to better understand a shared system of meaning, which is referred to as culture, identified as the most important aspect within this approach (Goulding 2004). Ethnographic studies observe, question and listen to participants in order to gain an inside knowledge of the culture (Hammersley and Atkinson 1983). Another distinguishing characteristic of the ethnographic approach is that the development of a theory is a potential outcome (Willis and Trondman 2000). In the context of this study, the ethnographic approach was considered as a way to understand the culture of the public health team. However, further development of the research question revealed that the study was not about understanding the culture within the public health team but, understanding interactions between public health and tourism teams and where synergies may occur. The ethnographic approach with its focus on the understanding of culture did not fit the study's research question focused on interactions and social processes.

Phenomenology

Phenomenology focuses on an individual's subjective experience within their daily world (Feneday and Muir-Cochrane 2006; Creswell 1994). This approach centres on the spatial and temporal elements of experience and social relationships, "essences"

(Schwandt 2001). The two main strands of phenomenology are Husserl's (1962) descriptive phenomenology and Heidegger's hermeneutic phenomenology. Hermeneutic phenomenology was initially considered as a methodological approach for this study, as it is located within the constructivist paradigm, thus aligning with the researcher's perspective (Annells 1996). The descriptive phenomenological approach however, excludes the researchers' knowledge and experience of the phenomena, through a process of bracketing (Schwandt 2001). In general, this approach was not used within this study as phenomenology focuses on the individual's experience of the phenomenon and within this study the aim is to evaluate the potential for synergies between wellbeing public health and tourism, thus the location of the phenomenon or participants that experience this phenomenon was still being explored. That said, a phenomenological approach could be utilised in a follow-up study, once the phenomena have been located and are clarified.

4.4 Research design and knowledge framework

The research knowledge framework, depicted in Figure 9, outlines the main knowledge claims or assumptions that are being brought to this study (Creswell 2003). The framework clearly illustrates the five interconnecting knowledge levels within the research process: the paradigm, ontology, epistemology, theoretical perspective, and methodology (Crotty 1998).

The research paradigm: constructivism

Within this study, the research paradigm of constructivism defines what knowledge can be known and how it can be gathered (Grix 2010; Babbie 2007) further guiding the research process (Daly 2007). The relevance of the positivist paradigm was considered in relation to current knowledge and using concepts, boundary objects, to promote collaboration, knowledge sharing, between public health and tourism communities of practice within local government and the theoretical gaps identified.

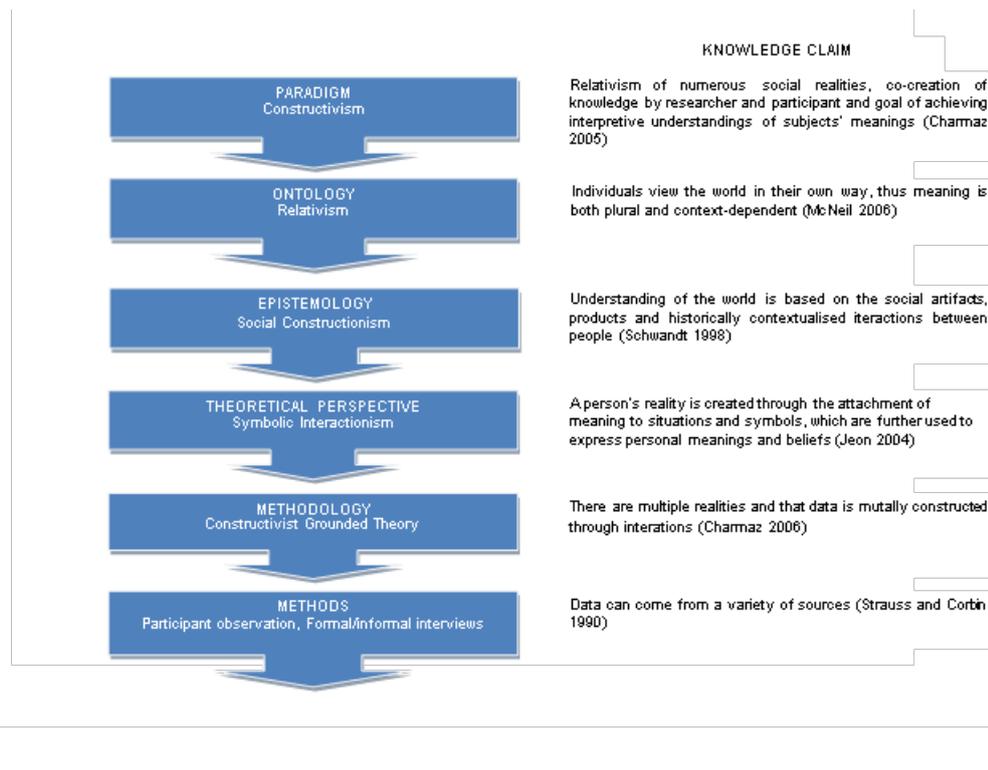


Figure 9: Research knowledge framework (adapted from Crotty 1998)

Positivism

The positivist paradigm is philosophically and epistemologically rooted in the perception that knowledge is identifiable and objective and can be measured using surveys and multivariate analysis techniques to enable statistical prediction (Denzin and Lincoln 2000). Positivism views social reality as existing separately from personal ideas or thoughts and is ruled by laws of cause and effect (Neuman 2003; Crotty 1998). Positivism is underpinned by the basic assumption that the primary aim of science is to develop objective methods that capture the closest version of reality (Ulin et al. 2004). These types of quantitative studies test relationships between variables to explain cause and effect relationships rather than aiming to understand social processes (Denzin and Lincoln 2003). These types of positivist quantitative studies in wellness tourism have resulted in a theoretical gap in the social processes that may enable collaboration between public health and tourism departments synergised through a wellbeing construct. This study focuses on the subjective experiences of the participants which are embedded in their multiple interpretations of reality. The positivist paradigm however, focuses on an objective understanding of the potential means of synergistic working. This study explores subjective knowledge of wellbeing and how it may synergise

collaboration, thus requiring individual's relativistic interpretations. A positivist approach to this research would not allow the exploration of synergies through interactions and processes, as it focuses on observed fact which can be quantifiably measured.

Constructivist paradigm

The identification of research gaps in understanding how wellbeing, public health and tourism could work together revealed the types of knowledge required to understand the social processes which could catalyse collaborative working between departments within the local government. This study has been organised within the constructivist research paradigm, which refutes the existence of an objective reality, rather putting forward that realities are social constructions of the mind and that there are a wide range of constructions (Charmaz 2014; Guba and Lincoln 1989). This study focuses on how participants make sense of their realities and the ways in which meaning is constructed. Thus, the researcher focuses on how participants make sense of events and experiences rather than in the actual events and situations themselves.

The research paradigm of constructivism has been increasingly used within health-related studies hence, being appropriate for this study with a focus on wellbeing (Appleton 2002; Koch 2000; Huebner and Betts 1999). Constructivist knowledge claims brought to this study assist the researcher in framing assumptions about the relativism of numerous social realities, the co-creation of knowledge by the researcher and the participant, and the goal of interpretive understandings of participants' meanings (Charmaz 2005). Approaching this study as a constructivist, the researcher views grounded theories as consequences of emergent processes that arise through interaction. Moreover, researchers construct their theories from the material of the interactions as lived and witnessed. The denial of an objective reality thus, assumes a relativistic ontological position (Guba and Lincoln 1994).

Ontology: relativism

Ontology is linked to the philosophical question about the existence of things and relation to the external world (Corbetta 2003). Ontology can be understood as the study of being, the nature of existence. The main ontological question is a matter of what, and refers to the nature and the form of social reality and its characteristics. Further, it is proposed that researchers embrace different realities (Creswell 2007) thus, it is important to situate the researcher's stance towards the nature of reality (Mason 2002).

The constructivist paradigm holds that individuals view the world in their own distinctive way thus, meaning is both fundamentally plural and context-dependent (McNeil 2006). This is representative of the world of relativism and is reflective of the postmodern assumption that suggests that all knowledge is embedded culturally, politically and

historically which is further framed by both the values and experiences of those who create it (McNeil 2006). In addition, Wakefield (1995) contends that these situation-specific meanings are fundamental to the understanding of human experience. Hence, in the construction of a theory, this study considers the plurality and context-dependency of meaning. The ontological claim is further embedded within the epistemology of social constructionism, which assumes an understanding of the world based on social artifacts, products and historically contextualised interactions between people (Schwandt 1998).

Relativism is evidenced to be embedded in later strands of grounded theory, where Strauss and Corbin (1990) maintain that a reality cannot be known, rather it is always interpreted. Additionally, Strauss and Corbin (1994) claim that knowledge is closely connected with time and place, truth is enacted, and refers to local and specific constructed realities. The epistemological assumptions underlying explanations of grounded theory methodology have been suggested to have developed over the last thirty years (Annells 1996). Charmaz (1989) further emphasises that grounded theory methodological analysis can be further enriched by clarifying the researcher's epistemological stance. From this perspective, Charmaz (1989) also cautions that grounded theory as a methodology can be misused if the researcher is not fully aware of the epistemological assumptions and underlying theory. Where ontology is interested in 'what is', epistemology is interested in 'what it means to know' (Gray 2009).

Epistemology: social constructionism

Epistemological assumptions are related to how the researcher knows what they know (Creswell 2007). Epistemological positions are often divided, based on whether they are foundationalist or anti-foundationalist, a simplified conceptual continuum of key epistemological positions. Foundationalism proposes that knowledge must be based upon indisputable truth that is logically deduced (Hughes and Sharrock 1997). Central to this viewpoint, is that reality is believed to exist separate to our knowledge of it (Grix 2010). Conversely, anti-foundationalists believe that reality is constructed by human actors (Grix 2010). The other fundamental belief is that there is no central value that can be either rationally or universally grounded. The importance of these starting points cannot be understated as they are significant based on their interrelationship to ontology, epistemology, methodology and methods, the key foundations of research (Grix 2010).

The social constructionist approach is based on the assumption that an understanding of the world is based on the social artifacts, products and historically contextualised interactions between people (Schwandt 1998). Charmaz (2014) acknowledges that social constructionism has a strong connection to the constructivist paradigm and constructivist grounded theory. The four key assumptions associated with social constructionism as they relate to this study are:

- (1) Observations made in the field are interpretations that are based on unbiased observations of the world;
- (2) Categories and concepts used have both historical and cultural specificity, thus differences would be expected within the last fifty years;
- (3) In understanding organisational dynamics, the researcher recognises that knowledge is sustained through social processes and that the role of language is particularly interesting; and
- (4) Knowledge and social action are interwoven, hence there are a variety of social constructions of the world that will produce a range of actions.

Theoretical perspective: symbolic interactionism

Crotty (2003) proposes that the theoretical perspective acts as the philosophical stance which informs the methodology, further providing the context for its process and grounds its logic and criteria. The theoretical perspective guiding this study is symbolic interactionism, which postulates that a person's reality is created through the attachment of meaning to situations and symbols, which are further used to express personal meanings and beliefs (Jeon 2004). The main focus of symbolic interactionism is on human activity and the interrelationships that exist within experiences, particularly within interpersonal meetings (Schroeder 1981). This theoretical viewpoint is particularly appropriate to guide this study as there is a focus on situational meanings as they may potentially lead to collaborative synergies.

Timmerman and Tavory (2007) maintain that grounded theory methodology is anchored within the theoretical perspective of symbolic interactionism. One of the foundational questions in symbolic interactionism is, what common set of symbols and understandings have arisen to provide meaning to human interactions (Bryman 2008)? Parallel to the aim of this study, the main emphasis of this perspective is on the shared meanings that are created through human interactions, and the meanings that then become reality (Patton 2002). Symbolic interactionists contend that interaction is a continual process where the individual is continually interpreting the symbolic meaning within their environment (Bryman 2008). From the perspective of the researcher, it requires that the nuances of interpretation are understood as the actors construct their actions (Blumer 1962).

Symbolic interactionism is recognised as being both a theory of human behaviour as well as an approach to inquiry that focuses on individual and group behaviour. The principle notion emerging from Mead's (1934) interactionist perspective is that the self is defined through social roles and expectations of those in society. Moreover, he argued that individuals come to understand collective social definitions through the process of socialisation (Annells 1996). This viewpoint maintains that individuals are in a constant

process of interpretation and definition, in their move from one situation to another (Eaves 2001).

A former student of Mead's, Blumer developed the three core assumptions of symbolic interactionism, which are: (a) people's actions towards something are based on ascribed meanings, (b) meanings are produced through social interaction; and (c) meanings are adapted through an individual's interpretive process (Blumer 1969). While there has been much evolution in the symbolic interactionist perspective since Blumer's conception, these three premises remain a benchmark (Fine 1993).

Applied to theorising intra-organisation synergies through boundary objects within this study, these premises support a means for understanding human-object relationships and the construction of meaning. From this perspective, the study focuses on: how participants' interactions with the concept of wellbeing are based upon meanings that they ascribe; how ascribed meanings to wellbeing are produced through the processes of social interaction; and how wellbeing meanings are adapted through each participant's process of interpretation. Also, it is acknowledged that the meanings of boundary objects (wellbeing) perceived are neither innate, individual, nor static. Rather, these objects are defined within the context of the situation and through interaction with others coupled with the awareness of community and societal expectations.

Much literature proposes that symbolic interactionism is a foundation of grounded theory methodology, where grounded theory is recognised as a method of symbolic interactionism (Glaser 2005). Grounded theory methodology aiming to develop explanatory theory about social life patterns, emerges from symbolic interactionism (Chenitz and Swanson 1986). Where it is further contended that symbolic interactionism and grounded theory make for a strong 'theory-methods-package' (Clark 2006; 2005; Fujimura 1992; Star 1989).

Methodological considerations

Grounded theory methodology offers a set of research strategies to study the experience of boundary object interaction. This study uses grounded theory methodology to understand people in local government, from public health and tourism communities of practice, and assesses how wellbeing as a boundary object effects the development of synergistic alliances. The grounded theory approach is proposed to be the most appropriate to achieve the study aim and objectives and best respond to the main research inquiry, as the literature indicates that there is a theoretical gap in extant knowledge explaining how wellbeing may synergise public health and tourism communities of practice. The main goal of grounded theory methodology is to develop an explanatory theory of social processes that are grounded in the data (Eaves 2001;

Glaser and Strauss 1967) through the examination of meaning as constructed through interactions (Strauss and Corbin 1998a). As the main aim of this study is to explain synergistic processes between local public health and tourism practitioners, grounded theory is an appropriate research methodology.

The main aim of grounded theory methodology is to explore social processes and better understand the diversity of interactions that produce variation within that process (Heath and Cowley 2004). Grounded theory methodology provides a set of useful tools to better learn about individuals' perceptions and feelings regarding a particular subject area.

It is advised that grounded theory is an appropriate methodology to use in under-researched areas (Burck 2005; Chenitz and Swanson 1986). In addition, Locke (2001) suggests that grounded theory methodology is particularly appropriate for new theorizing in substantive areas within management studies, in practice-oriented studies, and exploring situated processes related to individual and or group behaviour. In past studies purporting to use grounded theory methodology, it is advised that they tend to be generally lacking an explanation as to how it has been applied (Charmaz 2006; Henry et al. 2005). Grounded theory methodology was selected for this study as it was both consistent with the research query and the researcher's epistemological assumptions. The aim of the study is to make knowledge claims about the social production of meanings about concepts and actors within an actual setting (Gephart 2004). Therefore, this study, seeks to contribute to the methodological body of knowledge pertaining to constructivist grounded theory and offer flexible procedures to inform future studies.

4.5 Historical overview of grounded theory

Grounded theory methodology is primarily associated with qualitative research (Glaser and Strauss 1967). The main aim of the methodology is to construct a theory that is grounded in the data. Thus, grounded theory studies do not focus on testing hypotheses from existing theoretical frameworks, theory is grounded in the empirical data that is collected from the field. Grounded theory consists of unique methodological elements, i.e., theoretical sampling and constant comparative analysis which distinguish it from other types of research methodologies. Another unique feature of grounded theory is that data collection and analysis occur simultaneously opposed to a more linear order (Payne 2007).

Within its historical context, grounded theory emerged as a reaction to the dominance of quantitative research in the 1960's (Denzin and Lincoln 2005; Seale 2004). The emergence of grounded theory methodology challenged the quantitative hegemony of the day where studies were predominantly logico-deductive, testing grand theories (McGhee et al. 2007). Laydner (1993) refers to the grand theories as being speculative

as they have not grown out of research, thus being ungrounded, and are seen to lack validity as they do not fit in the real world and remain unconnected to the people concerned.

Grounded theory was originally developed in sociology in 1967 by researchers, Barney Glaser and Anselm Strauss (Creswell 2007). The approach contrasted the sociological theory of the day, in that grounded theorists maintained that theory ought to be grounded in the data, particularly within human actions and social processes (Creswell 2007). Many researchers have claimed to base their work on grounded theory since the publication of Glaser and Strauss' 1967 seminal work, *Discovery of grounded theory* (Hood 2007), the publication associated with a breakthrough due to its systematic procedures for qualitative studies (Hallberg 2006). Contextually, this was significant due to the increasing popularity of quantitative research methods within the 1960s and the advantage they acquired over qualitative methods. Qualitative research was viewed as being unsystematic, impressionistic, and unreliable, thus, being vulnerable to attack (Hallberg 2006).

While there is a claim that as a result of its prolific use, everyone must be familiar with grounded theory, it is questioned whether there are actually shared definitions and basic assumptions. One of the noted challenges in using the grounded theory approach is that it has been associated with multiple meanings and additionally laden with countless misunderstandings, further complicated by competing versions of the methodology (Charmaz 2006). One of the notable gaps within many grounded theory studies is that there is a general lacking of explanation in how it has been applied (Charmaz 2006; Henry et al. 2005).

Strauss and Corbin (1990) use the term grounded theory to mean that the theory was derived from the data. Within this approach, data collection, analysis, and developed theory are all very closely related to one another (Strauss and Corbin 1990). Importantly, the researcher does not begin a project with a preconceived theory, rather the researcher starts with an area of study, allowing the theory to emerge from the data (Strauss and Corbin 1990). Charmaz (2014) contends that the grounded theory method is one which is dependent upon the use of constant comparative methods and engagement.

The main intent of a grounded theory study is to transcend description and to construct a theory, viewed as an abstract analytic schema of a process (Strauss and Corbin 1998b). From this perspective, the researcher develops a theory of action, process or interaction which is formed by the views of a substantial number of participants (Strauss and Corbin 1998b). The main emphasis of the approach is on the importance of linking explanations to situations in the real world, grounded in the data (Denscombe 2010). As such, grounded theory is recognised to be a good fit with real world research, as the

focus of the research is on the individual and the world through their experience (Hallberg 2006).

Glaser and Strauss' (1967) publication of *The Discovery of Grounded Theory* was both a clear introduction of grounded theory methodology and a means to legitimize qualitative research and inquiry (Charmaz 2009). Significantly, the collaborations of Glaser and Strauss brought together two distinct philosophical traditions: Columbia University positivism and University of Chicago pragmatism (Charmaz 2009). Glaser was educated at Columbia University which was known for its focus on positivistic methodology (Hallberg 2006). The emphasis of positivism is on the scientific method, where generalities can be discovered to explain empirical phenomenon. Strauss (who studied at the Chicago School of pragmatism) maintained the ideas of pragmatism, which informed symbolic interactionism, are also reflected in grounded theory methodology (Charmaz 2014; Blumer 1969; Mead 1934).

Grounded theory (GT) is recognised as a general methodology for constructing theory which is grounded in data that has been systematically collected and analysed (Strauss and Corbin 1998). Theory is developed through continual interchange between analysis and data collection. Glaser and Strauss intended to move qualitative inquiry into the area of explanatory theoretical frameworks, offering a conceptual understanding of the studied phenomenon (Charmaz 2006). The grounded theory approach, in recent years, has become one of the most popular qualitative research methodologies spanning across a range of disciplines (Stern and Porr 2011; Denscombe 2010). As well, GT approach has also become popular within the academy of management (Glaser 2008; Gummesson 1991).

An additional rationale for the selection of grounded theory methodology within this study is that while there are key tenets to adhere to, the researcher is not beholden to methodological dogma (Stern and Porr 2011). Therefore, this flexibility allows the researcher to tailor the approach to the unique aspects of the research contexts without compromising methodological integrity. Schwandt (1990) recognises that methodology is dynamic as it is constantly evolving from where it was historically situated. That said, grounded theory has been modified (Charmaz 2006; Clarke 2005; Strauss and Corbin 1998a) since the original proposed conception in 1967.

Strands of grounded theory

Over the decades there have been modifications made to the grounded theory process (Charmaz 2010; Corbin and Strauss 2008) leading to the emergence of three distinct strands: Glaserian, Straussian and Charmazian (Hood 2007). While each strand retains its own unique emphasis, each strand retains the core principles of theoretical sampling,

constant comparison and theory development (Bradley 2010). The researcher within this study recognises the value of each of the strands of grounded theory and does not purport that one strand is superior to another; rather that selection is based on the best fit for the specific research inquiry and embedded within the researcher's paradigm and philosophical assumptions. Hence, each strand of grounded theory will be critically evaluated in terms of its potential alignment with this study.

Glaserian

The original conceptualised form of grounded theory often referred to as traditional or classic grounded theory is recognised as being either positivistic or post-positivistic in its intent (Lincoln and Guba 2005). In this approach to grounded theory, there is a belief in the notion that there is a truth that is just waiting to be uncovered (Mills et al. 2007). This form of grounded theory is also known as Glaserian (Cutcliffe 2003) to recognise the ontological and epistemological assumptions of its creator Barney Glaser (Mills et al. 2007).

It is suggested, though he has never explicitly stated the idea, that Glaser (2002) makes an assumption that there is an objective or 'real' reality and the researcher is merely a neutral observer, discovering data in a neutral way (Hallberg 2006). One of the critiques of Glaser's grounded theory is that it is based on positivistic assumptions about objectivity, neutrality, reproducibility, and an underlying belief that not only does a true reality exist but it can be reproduced without influence by the researcher (Charmaz 2000).

The classic strand of grounded theory acknowledged as objectivist theoretical categories being discovered in the data, and the external world being observed by a neutral observer, is no longer plausible since the interpretive turn in qualitative research (Denzin and Lincoln 2000). This study, acknowledging multiple realities, co-creating interpretations by researcher and participants, does not fit within this strand of grounded theory and its associated knowledge claims.

Straussian

Shortly after the publication of the *Discovery of grounded theory* (1967), the paths of Glaser and Strauss diverged (Mills et al. 2007). At that point, Strauss sought out a version of grounded theory that addressed his concern about action being central to process and structure (Corbin 1991). Strauss published *Qualitative analysis for scientists* (1987), which more clearly outlined his approach to grounded theory (Hallberg 2006). Strauss' background as a relativist, pragmatist and symbolic interactionist is suggested to have

influenced his approach to grounded theory where action is central to analysis (Mills et al. 2007).

The Strauss and Corbin collaboration, *Basics of qualitative research: grounded theory procedures and techniques* (1990), describes this new reformulated grounded theory approach and procedures for systematic analysis. This view of grounded theory is suggested to be more pragmatic than Glaser's and would seem to reject positivistic assumptions (Hallberg 2006). One of the key arguments put forth by Strauss and Corbin is that reality cannot be fully known, yet it can always be interpreted (Strauss and Corbin 2008).

For this study, the Straussian strand of grounded theory is not being utilised based on the fact that this approach postulates that there is one grounded theory approach, thus it lacks a flexibility to research that allows for the best fit for the type of inquiry. Further, this strand is recognised as bridging the Glaserian theory of grounded theory to a Charmazian constructivist stand. From this perspective, relationships between the researcher and the participant are viewed to be reproductions of participants' realities (Strauss and Corbin 1990, 1998a), thus, overlooking the inter-relationships between researcher and participant, which is where data is constructed. Where the Straussian strand advises the researcher to minimise the interference of subjectivity in the analysis (Strauss and Corbin 1998a), the constructive strand recognises the intersubjective construction of data (Hall and Callery 2000). That said, this study-which acknowledges the social construction of data- falls outside of the guidelines for this strand of grounded theory.

Charmazian

Most recently, Charmaz (2014, 2006) has promoted the constructivist grounded theory approach which makes the assumption that rather than one 'real reality', there are multiple simultaneous realities (Hallberg 2006). Additionally, there are numerous researchers who acknowledge that grounded theory is underpinned by the constructivist paradigm (McCann and Clark 2003; Charmaz 2000; Norton 1999). This study is influenced or rooted in the constructed grounded theory approach, as outlined by Charmaz (2014; 2006). One of the merits of utilising the constructivist grounded theory approach is its 'flexible approach' to grounded theory which will be fit for purpose in this study of wellbeing, public health and tourism research (Bradley 2010; Charmaz 2006). It has been further proposed that 'fit for purpose' or flexible approaches to grounded theory may enhance analysis, further providing richer data (Bradley 2010).

Constructivist grounded theory is based on the assumption that knowledge is produced through grappling with empirical challenges (Charmaz 2009). This approach is also premised upon the claim that knowledge is viewed as resting upon social constructions

(Charmaz 2009). The distinctions between traditional and constructivist grounded theory are illustrated within Table 4, comparing objectivist and constructivist grounded theory. This study and the approach to grounded theory, account for the theoretical and methodological developments of the last four decades, where grounded theory methods are viewed as a set of principles and practices not mere prescriptions or packages (Charmaz 2006). The approach is based on the assumption that any theoretical development offers an interpretive depiction of the studied world and not an exact replica (Charmaz 1995, 2000; Guba and Lincoln 1994; Schwandt 1994).

OBJECTIVE GROUNDED THEORY APPROACH	CONSTRUCTIVIST GROUNDED THEORY APPROACH
Foundational Assumptions	Foundational Assumptions
Assumes an external reality	Assumes multiple realities
Assumes discovery of data	Assumes mutual construction of data through interaction
Assumes conceptualisations emerge from data	Assumes researcher constructs categories
Views representation of data as unproblematic	Views representations of data as problematic, relativistic, situational, and partial
Assumes the neutrality, passivity, and authority of the observer	Assumes the observer's values, priorities, positions, and actions affect views
Objectives	Objectives
Aims to achieve context-free generalizations	Views generalizations as partial, conditional, and situated in time, space, positions, actions and interactions
Aims for parsimonious, abstract conceptualizations that transcend historical and situational locations	Aims for interpretive understanding of historically situated data
Specifies variables	Specifies range of variation
Aims to create theory that fits, works, has relevance, and is modifiable	Aims to create theory that has credibility, originality, resonance, and usefulness
Implications for Data Analysis	Implications for Data Analysis
Views data analysis as an objective process	Acknowledges subjectivities throughout data analysis
Sees emergent categories as forming the analysis	Recognises that co-construction of data shapes analysis
Sees reflexivity as one possible data source	Engages in reflexivity
Gives priority to researcher's analytic categories and voice	Seeks and re(represents) participants' views and voices as integral to the analysis

Table 4: Comparing objectivist and constructivist grounded theory (Charmaz 2009)

While there are different points of emphasis among practitioners, there are agreed upon commonalities, as depicted within Table 4 that maps the contrasts to the grounded theory process. While there are parallels between the strands of grounded theory, there are characteristics of the constructivist grounded theory which are arguably distinct. Constructivist grounded theory emphasises that data is a constructed result of the continual interaction between the researcher and participant (Hallberg 2006). Charmaz (2014) emphasizes the importance of entering the area of study and working to learn from the inside. The main focus in analysis is on how the participant creates his or her meaning of reality (Hallberg 2006). This type of theory development runs parallel with

symbolic interactionism which also presupposes emergent multiple realities (Charmaz 2006). Understanding the historical context of grounded theory is critical to the methodological positioning within the research paradigm, ontology, epistemology, and theoretical perspective.

4.6 The role of constructivist grounded theory in this study

The main assumption of grounded theory is that within the dynamic social reality, humans are reflexive, social beings that use shared symbols in order to interpret their world, build and convey meanings that guide actions. From this orientation, grounded theory connects the pragmatic concerns in daily life with ways of exploring a shared foundation of experience (Watson 2000). The emergent design allows for the flexibility needed to have the focus remain on participants' experience, where the researcher engaged in the concurrent data collection and analysis can follow-up on leads further seeking out meaningful information within the study.

This study is guided by the constructivist (Charmazian) strand of grounded theory which assumes multiple realities and the mutual construction of data through interaction. This 'fit for purpose' or flexible approach to grounded theory, may also promote enhanced analysis, further providing richer data (Bradley 2010). While there are points of departure in the strands of grounded theory, it is contended there are also agreed upon commonalities (Charmaz 2006). This research will be undertaken using research stages in an iterative process, where all data collected will ultimately contribute to the construction of a theory that will be grounded in the data, as summarised in Figure 10. The research strategy reflects the researcher's understanding about the structure employed within this study that will best optimise data collection, analysis and theoretical construction. Therefore, this strategy may undergo several iterations during the research process, which will be further described within the methodology section in the next chapter which focuses on methodology.

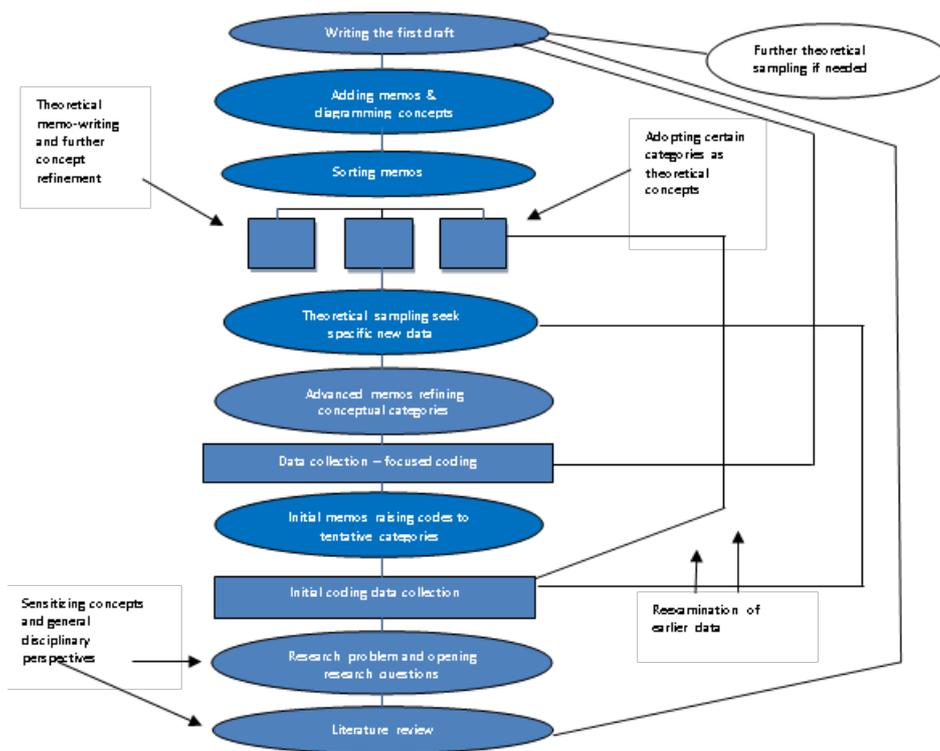


Figure 10: Grounded theory research strategy (Adapted from Charmaz 2006)

Grounded theory emerging from sociology (Starks and Trinidad 2007), and precisely from symbolic interactionism, posits that meaning is understood through interactions with others in social processes (Blumer 1986; Jeon 2004). Ultimately, the main goal of a grounded theory study is to develop an explanatory theory where there is a noted theoretical gap. This study utilises grounded theory methodology to develop a theory that is grounded in the data and provides explication about how social interactions and processes may synergise public health and tourism, through the boundary object of wellbeing.

Timmerman and Tavory (2007) maintain that grounded theory methodology is anchored within the theoretical perspective of symbolic interactionism. Grounded theory methodology is selected in this study as there is no extant theory to explain the construct of wellbeing as a means to synergise tourism and public health. Thus, this research is not approached with a preconceived theory to test; rather the theoretical model will be constructed from the data (Strauss and Corbin 1990). One of the main benefits of employing grounded theory methodology within this study is, due to its flexible nature, the researcher can tailor the approach to unique aspects of the study without compromising methodological integrity (Stern and Porr 2008).

It is suggested that the philosophical basis of grounded theory be considered, in order to assess the alignment with the researcher and the potential for a comfortable “fit”

personally (Annells 1996). Thus, a researcher who identifies their ontological and epistemological assumptions can be true to their beliefs within the process of inquiry. The constructivist strand of grounded theory acknowledges that the researcher is not neutral in their approach to the study (Charmaz 2006). Social processes involving critical thinking and discussion in dynamic environments are likely to accompany a variety of subjective experiences arising in interaction and emotion.

Grounded theory methodology is a particularly good fit for this study as it focuses upon social processes (Stauss and Corbin 1990). Additionally grounded theory is appropriate as grounded questions tend to be oriented towards action and process (Strauss and Corbin 1990). Within this study, the potential for synergies represents the action orientations which seek to understand the role that social interaction plays in developing meaning about the concept of wellbeing (Schwandt 2001; Blumer 1969).

The role of the literature

Within grounded theory research, the timing of the literature review is a divisive issue among the different strands of this methodology (Dunne 2011). From the constructivist strand of grounded theory, however, it is accepted that literature is collected at an early stage in the research process and again during the writing up, being interwoven into the theory as an additional form of data for constant comparison (Glaser 1998). In this study, the initial review of the literature was undertaken to determine the gaps in knowledge within the substantive area of study. This literature review was important in revealing the lack of extant theory explaining the phenomenon of intra-organisational synergies further leading to the development of the primary research question and methodological selection (Payne 2007; McCann and Clark 2003).

Additionally, the initial literature review provided both the rationale for this study and justification for the use of grounded theory methodology (McGhee et al. 2007; Coyne and Cowley 2006). Secondly, the review allowed the researcher assurance that the study had not already been conducted (Chiovitti and Piran 2003). Thirdly, the review allowed the study to be contextualised (McCann and Clark 2003) in turn helping to better orient the researcher to how similar phenomenon had been studied in the past (McMenamin 2006; Denzin 2002). Fourthly, it provided an opportunity for the researcher to gain theoretical sensitivity (McGhee et al. 2007; Strauss and Corbin 1998), develop sensitising concepts (Coffey and Atkinson 1996) within the substantive area. Fifthly, it helped to promote clarity around concepts related to theory development (Henwood and Pidgeon 2006) which while often contentious is defended by Coffey and Atkinson (1996) who believe that grounded theory researcher's open-mindedness ought not be mistaken for empty mindedness.

Sensitising concepts

Sensitising concepts is a term that was originally coined by Blumer (1954), an American sociologist who used the term to contrast definitive concepts. Blumer referred to a definitive concept, as one common to a class of objects that are clearly defined. More recently, social researchers review these concepts as interpretive devices that mark a starting point within qualitative studies (Padgett 2004; Patton 2002; Glaser 1978). The significance of these features, it is suggested, is in their ability to highlight salient features of social interaction and guide research within specific contexts (Bowen 2006). Where research tends to begin with these concepts, this may occur whether it is stated by the researcher or not, whether or not they are aware of them. (Gilgun 2002).

The researcher within this study has used sensitising concepts as background ideas which in turn inform the whole research inquiry process, being a means to use, organise and understand experience (Charmaz 2003). Where researchers have been cautioned about using sensitising concepts as they may draw attention away from important aspects of the study (Gilgun 2002), this study acknowledges that the survival of a sensitising concept will depend upon the data and emergent concepts which will either support or displace them (Padgett 2004).

In this study the conceptual framework serves to link concepts and that may potentially be the impetus for theory formulation (Seibold 2002). Past grounded theory studies have used sensitising concepts to form their conceptual framework (Bowen 2006). In this study these concepts are derived from a review of literature on wellbeing, health, tourism, boundary objects and knowledge transfer. The reviewed literature will build a conceptual framework from sensitising concepts which in turn will contribute to theoretical development.

Role of the researcher

The multitude of methodologies encompassed by qualitative research have been conceptualised as a bricolage, and the researcher as a bricoleur. Lévi-Strauss (1966) views the bricoleur as a 'jack of all trades', essentially a do-it-yourself professional. The bricoleur strives to produce a bricolage, which are practices that are solutions in the form of a solid explanation (Denzin and Lincoln 1998) where the method is seen as an emergent solution (Weinstein & Weinstein 1991). The French word, bricoleur, is a handyman or handywoman who utilises available tools in order to complete a task (Geertz 1988). Kincheloe (2001) goes a step further in recognising the bricoleur as being far more skilled than a handyman being viewed alternatively as a seeker of interconnections, precarious bonds between disciplines and bodies of knowledge. From this perspective, the role of the bricoleur can be viewed as that of boundary-work,

operating at the margins between formal knowledge and boundary knowledge and working to weave them together (Lincoln 2001).

It is emphasised that the role of the researcher within qualitative research is vital to the process, where it is acknowledged that this type of research is viewed as an instrument through which to conduct data collection and analysis (Brown et al. 2002). Additionally, within the grounded theory approach it is important for the researcher to show a theoretical sensitivity to the nuances within the data, where having sensitivity refers to having insight and being able to give meaning to both happenings and events within the data (Strauss and Corbin 1998a). This sensitivity is achieved through the combination of a researcher's knowledge and experience which brings meaning to the data in a systematic and aware manner, being sensitive to meaning without forcing explanations on the data (Strauss and Corbin 1998a).

Within this study, the researcher worked to maintain a stance of theoretical agnosticism (Henwood and Pidgeon 2003), by being aware of the sensitising concepts that were brought into the field and having incisive use of concepts drawn from the literature in the exploration of synergistic alliances and boundary objects. Suddaby (2006) suggests that it is important to remind ourselves as researchers that we are only human, and that our observations are both a function of who we are and what we are hoping to see. Furthermore, it is emphasised that the fit between the methodological approach to research and the researcher is quintessential to achieving quality in grounded theory methodology (Fendt and Sachs 2008). Thus, the selection of the methodological approach requires introspective reflection about beliefs, interests and values, which necessitates a coherent relationship between the researcher's paradigm, ontology, epistemology, and the selection of methodology.

Reflexivity

Where positivist studies adhering to the realist ontology promote the notion of scientific inquiry being a neutral and impartial activity, naturalistic inquiry conversely recognises how the relationship between the researcher and research inquiry ultimately shape the inquiry itself (Henwood and Pidgeon 1992). From this viewpoint, the researcher and participant are deemed to be interdependent in the social process of research. Hammersley and Atkinson (1983) refer to this as the reflexive character of the research. The process of reflexivity can be understood as an ongoing internal dialogue and critical evaluation of the researcher's position which is recognised to affect both the research process and outcome (Stronach et al. 2007; Guillemin and Gillam 2004; Pillow 2003). Past research suggests that relevant researcher's positioning includes: gender, race, age, sexual orientation, immigration status, personal experiences, beliefs, spoken

language, theoretical, political and ideological standpoint (Hamzeh and Oliver 2010; Padgett 2008; Primeau 2003; Finlay 2000).

Within qualitative research reflexivity is increasingly acknowledged to be a significant strategy in the process of creating knowledge (D'Cruz et al. 2007; Blaxter et al. 2006; Hammersley and Atkinson 2002). Where the aim of this process is to assess the ongoing effects of the researcher's positionality which in turn increase the credibility of the research findings by acknowledging the beliefs, values, knowledge and biases of the researcher (Cutcliffe 2003). Reflexivity can also enhance the quality of the research by permitting the researcher to consider the ways that they can both improve and challenge the co-construction of meaning (Lietz et al. 2006). The researcher's reflections on the study are discussed within Chapter 11: study implications, reflections and conclusions.

4.7 Conclusion

This chapter has outlined the rationale for the adoption of the constructivist grounded theory methodological approach for this study. The study's aims and research questions have influenced the selection of a qualitative research approach, embedded within the constructivist paradigm. The Charmazian constructivist grounded theory approach, clearly identifies the paradigmatic, ontological and epistemological knowledge claims, allowing the researcher to select the most appropriate methodological approach to address the research inquiry. This approach to grounded theory provides the greatest level of flexibility for conducting grounded theory research, allowing a 'fit for purpose' approach to constructing an explanatory theory showing how wellbeing, public health and tourism could be synergised. The approach considers the role of the researcher in the development of the theory and is aligned with the researcher's positionality, acknowledging multiple simultaneous realities. Charmaz's constructivist approach recognises the continual interaction between the researcher and the participant. The main focus in the analysis is on how the participant creates meaning of their reality, an important element in the evaluation of how the concept of wellbeing is interpreted in the arena of potential inter-departmental synergies. The knowledge framework outlined within this chapter provides the foundation for the methods selected within this study, which will be discussed within the next chapter.

5. METHODS

5.1 Introduction

This chapter will outline the methods used in this study within the constructivist approach to grounded theory. The questions guiding this study focus on understanding social processes associated with collaborative synergies. Grounded theory methodological steps will be detailed through each of the two phases of research that employ methods of participant observation and semi-structured interviews. An iterative and research process will be detailed outlining the interplay between inductive and deductive reasoning utilised in the simultaneous data collection and analysis processes. Each of the data analysis phases will trace the process from open coding through to category development and ultimately the construction of a theory. The last section will explain methods of evaluation associated with this study and the potential for generalizability or transferability of the findings.

5.2 Research design

Aim of the study

The study was designed to explore the following:

- Engagement processes in order to critically evaluate the potential for a strategic alliance between local public health and tourism communities of practice, bridged through the boundary object of wellbeing.

This study will additionally be guided by the following questions:

- (1) What meanings do public health and tourism team members' ascribe to the construct of wellbeing? What are the benefits of these meanings?
- (2) Do place characteristics influence synergies between wellbeing, public health and tourism?
- (3) What engagement experiences contributed to synergies between wellbeing, public health and tourism? What caused these engagement experiences?
- (4) What strategies were used to synergise public health and tourism communities of practice?
- (5) What were the consequences of these strategies?
- (6) What theory explains the phenomenon of finding ways to engage with a healthy tourism offer?

These questions, which are adapted from the '6 Cs of grounded theory', are intended to focus the processes of data collection, data analysis, and the dissemination of findings and discussion. Grounded theory methodology offers a set of research strategies for studying the experience of boundary object interaction. This study uses this methodology to understand social processes in local public health and tourism communities of practice

and assess how wellbeing as a boundary object contributes to the development of synergistic alliances. The grounded theory approach is proposed to be the most appropriate to achieve the study aim and objectives and best respond to the main research inquiry, as the literature indicates that there is a theoretical gap in extant knowledge explaining how wellbeing may synergise public health and tourism communities of practice. The main goal of grounded theory methodology is to develop an explanatory theory of social processes that is grounded in the data (Glaser and Strauss 1967; Eaves 2001), through the examination of meaning as constructed through interactions (Strauss and Corbin 1998). As the main aim of this study is to explore engagement experiences that contribute to synergies between wellbeing, public health and tourism locally, grounded theory is an appropriate research methodology.

Employing grounded theory allows for data to come from a variety of sources (Strauss and Corbin 1990; Khambete and Athavankar 2010). The specific methods selected for this study are, primarily participant observation and formal and informal interviews. Participant observation will be overt and be based in tourism and public health communities of practice situated within the local authority. Interviews will additionally be conducted to reveal meaning behind what has been observed (Stern and Porr 2011). Semi-structured interviews will be conducted with selected members of tourism and public health communities of practice, as this type of interview allows for greater flexibility within the conversations which further allows for exploration around either topic or experience (Lofland and Lofland 1995).

5.3 Overview of research strategy, timing and phase

This study is conceptualised as a two phased data collection/analysis process. Table 4 outlines the two phased study approach. The first phase of data collection took the form of participant observation within the primary care trust, the work setting of the public health team and took place for three weeks between September and October 2012. The second phase of data collection focused on conducting semi-structured interviews with employees with public health and tourism working with local government between September and November 2013, six months after the public health agenda had moved to the local council.

Ethics approval

Prior to the collection of data, ethics approval was granted through Bournemouth University's Research Ethics Committee (UREC). Additionally, the researcher completed the two mandatory online ethics modules. The main principles of ethics applied to this study include: a respect for autonomy, the process of seeking informed consent, non-

maleficence to the researcher, non-maleficence to the participants, and participants' confidentiality and anonymity.

Phase	Timing	Location	Approach/Methods
PHASE 1	Enter the field setting for three weeks between Monday September 24 th and Friday October 5 th , 2012.	Primary Care Trust (PCT)	<ul style="list-style-type: none"> *A desk situated within the public health unit to observe and participate in daily routines and select meetings *Shadowed selected senior public health employees *Reviewed public health web links and documents as means to provide backgrounds to understand observed actions *Data collection and initial coding
PHASE 2	Conducting qualitative semi-structured interviews between September and November 2013 (six months after the shift of the public health agenda to the local authority).	Bournemouth University and local council offices (location selected by participants based on their convenience).	<ul style="list-style-type: none"> *Entered the field with sensitising concepts derived from participant observation and initial literature review. *Semi-structured interviews conducted with purposive sample of 16 participants (8 from public health, 8 from tourism). *Digitally recorded and transcribed interviews. *Data analysis including: initial, focused, and axial coding, memo-writing and concept refinement.

Table 5: Research strategy

5.4 Phase 1 – participant observation

The first phase of this study involved a three week immersion within the field, involving participant observation conducted in September and October 2012 within the public health unit, prior to the move to the local authority, scheduled for April 2013. The researcher was granted access to work within the unit, and had access to public health intranet at a 'hot' desk amongst team members. During this immersive phase of data collection, the researcher participated and observed team members at four events and ten meetings. The high level of activity within the team, made it ideal for observation given the research questions. Meeting and event selection was based upon the study aim of evaluating the potential for synergies between tourism and public health communities of practice thus, tourism stakeholders were observed in multiple contexts.

Some of the questions that were explored within this initial phase of data collection include: How is wellbeing understood/utilised by local public health and tourism communities of practice?; What does wellbeing mean to members of the local public health community of practice?; and What is the influence of organisational change on engagement experiences with local tourism communities of practice? Each of these questions were addressed in observational notes that were coded using open, axial, and

focused coding methods which contributed to the development of the 'process of change' category and ultimately the study's explanatory theory. Manual data analysis from participant observation was downloaded into NVivo to contribute to conceptual development and saturation. These coding steps used to analyse both phases of data collected follow an iterative process and are detailed within Section 5.8: Data collection and analysis.

A significant focus in this grounded theory study is on the relationships between the researcher and the participant, where the data is constructed (Charmaz 2010). This is consistent with the theoretical perspective of symbolic interactionism and the epistemological foundations of grounded theory of this study. This study, acknowledges the intersubjective construction of the data, where reflexivity addresses the influence of investigator-participant interactions (Hall and Callery 2001).

5.5 Phase 2 – intensive interviews

Purposive sampling

Employing a purposeful selection of participants is a significant decision in a qualitative study. In grounded theory methodology, the term theoretical sampling refers to the process of selecting participants based on their ability to contribute to an evolving theory (Miles and Huberman 1994). Participants are to be theoretically chosen, so called theoretical sampling, in order to best assist the researcher in best developing the theory (Creswell 2007). Thus, participants for this study were selected according to set criteria identified by the researcher that was based on initial findings from the first phase of research, participant observation.

Within this study, participants were selected from public health and tourism employees with the local authority who would best contribute to theory development. In addition, members of wellbeing boards, which included local councillors, were selected to better understand the current local wellbeing agenda and identify potential knowledge brokers. Potential participants with the local council were contacted by telephone and/or e-mail in order to request interviews at a time and location that would best suit their schedule. Eight members from the public health team and eight members from the tourism team agreed to be interviewed as part of this study. Prior to the interview, participants were provided with a brief description of the study and an outline of the format and approximate duration of the interview.

Conducting the qualitative interview

Intensive interviews

Charmaz (2006) refers to an effective version of the interview data collection process as intensive interviewing. This process refers to an interview that is more a directed conversation (Lofland and Lofland 1984, 1995) and allows a more in-depth exploration of a specific topic or experience (Charmaz 2006). Burgess (1984, p.107) refers to this type of interview as “a conversation with a purpose”. Within qualitative research in general, it is accepted that knowledge is both situated and contextual thus, the role of the interviewer is to ensure that pertinent contexts are focused to produce situated knowledge (Mason 2002). This type of interview method can be structured as an interview with broad open-ended questions, loosely guiding exploration of topics and or utilising semi-structured more focused questions (Charmaz 2006). The main element of etiquette that distinguishes intensive interviewing is in the fact that the researcher expresses interest in the conversation and wants to know more. In this type of interview, the researcher goes to a greater depth than in an ordinary conversation, examining prior events, thoughts and feelings anew. The lists of benefits of employing this type of interview style are numerous, and include:

- Delving beneath the surface of described experience;
- Pausing to explore a statement or topic;
- Allowing the researcher to request more detail or explanation;
- Inquiring about the participant’s thoughts, feelings, and actions;
- Guiding the participant on the subject;
- Re-addressing points made earlier;
- Restating interviewee’s point to confirm accuracy;
- Altering pace, either slower or quickening;
- Shifting the directed topic;
- Validating the interviewee’s perspective or action;
- Using observational and social skills to further the discussion; and
- Respecting the interviewee, where appreciation for participation is expressed (Charmaz 2006).

Interview guide development

In the planning stages for the intensive interview phase of research, a semi-structured interview guide was developed, and was subject to future iterations, as shown in Appendix 1. The two prior research phases, concept sensitivity through the review of literature, and research questions influenced the development of the interview guide.

This phase of data collection and analysis was guided by a central overarching research aim and research questions and was further directed by a set of issue and topical subquestions. Both issue and topical subquestions were employed to follow the central questions. Stake (1995) suggests that issue subquestions speak to main challenges that need to be resolved and the topical subquestions aim to address the perceived needs

for information. For example within this study, the following questions informed the interview guide development.

Central question

- How is wellbeing understood/utilised by local public health and tourism communities of practice?

Issue subquestions

- What does wellbeing mean to members of the local public health community of practice?
- What does wellbeing mean to members of the local tourism community of practice?
- What are the underlying themes and contexts that account for the conceptualisations of wellbeing?
- Are there universal structures that catalyse feelings and thoughts about wellbeing?
- Are there knowledge brokers in each community of practice and what may influence their engagement in knowledge sharing activities?

Topical subquestions

- What are the general questions that emerge in the first review of the data? (open coding)
- Given the phenomenon of interest, what caused it? What were the contextual and intervening conditions? What were the resulting strategies or outcomes? What were the consequences?

Interview procedure

Intensive interviews were conducted with the selected sample of participants evenly distributed between public health and tourism communities of practices within the local authority. In total there were sixteen interviews conducted, with data collection and analysis occurring simultaneously until categories were saturated to enable the construction of a theoretical model (Charmaz 2006). Interviews were conducted by the researcher, on-site, in a closed door office setting, as to be as confidential as possible. Interviews (conversations) were each designed to be between thirty and forty-five minutes in length. At the onset of each interview, the participant was read a preamble from the participant information sheet, as outlined in Appendix 2, and received written consent for participation in the study and permission to digitally record the interview.

All interviews were recorded using a digital recorder. The intensive interview process was prompted through the use of an interview guide that was designed to guide meaningful conversation with the interviewee. The main purpose of conducting interviews was to further understand meanings, tasks and beliefs associated with wellbeing within potentially disparate communities of practice. Interview prompts were used and modified in order to optimise the collection of rich data. At the end of the

interview the participant selected their pseudonym based on an alphabetised list of names, see Appendix 3, amalgamated from popular baby names currently reported in England and North America. Within this study, the order of the interviews will correspond with placement in the alphabet as participants were directed to select a pseudonym within a certain section of names.

5.6 Data management

Transcription of interviews

All interviews were transcribed verbatim by the interviewer promptly after the interview was conducted, in order to capture the most accurate version. Non-verbal elements, for example body positioning and facial expressions were included within the interview transcriptions to provide greater context and meaning in data analysis. Interviews varied in length but, were on average about thirty-five minutes. Each interview took approximately four hours to transcribe, which represented about sixty-four hours altogether. In order to protect participants' confidentiality and anonymity any identifying elements within the interviews were deleted.

Use of NVivo 10

There have been a number of computer packages developed to assist with the organisation and development of qualitative data. The Economic and Social Research Council (ESRC) advise that students need to acquire skills in the use of computer assisted qualitative data analysis software (CAQDAS) (Economic and Social Research Council 2001; Richards and Richards 2000). One of the original critiques of NVivo and CAQDAS, however, is that it would remove the researcher from the analysis process and transform qualitative research into a rigid, automated analysis, where in reality analysis necessitates human interpretation (Kelle 1995). The quantification of rich qualitative data is not the fault of the computer software but that of the researcher. Past research contends that it is the researcher who needs to interpret, conceptualise, study relationships and construct a theory (Bringer et al. 2000). Scholars advise that while NVivo can assist with these tasks, it does not analyse qualitative data (Bringer et al. 2006; Fielding and Lee 1998; Macmilliam and Koenig 2004). Another critique of using CAQDAS is that these programmes distance the researcher from the data (Weitzman 2000) however, it could be argued that NVivo is a powerful organisational tool which reduces the researchers time spent on clerical tasks, allowing more time for data analysis (Côté et al. 1993).

Interview data, field notes and memos were all uploaded into NVivo10 which is the recommended and available qualitative software at Bournemouth University. NVivo 10, which was released in 2012 by QSR International, assisted the researcher organise and

analyse data. This qualitative software provides an efficient means for the researcher to code data around themes, highlighting text and moving it to appropriately labelled nodes or categories. There are concerns held by some qualitative researchers that they will force a rigid framework on the analytic process, due to the fact that they originated within the statistical quantitative paradigm (Seale 2005). However, the benefits of using such qualitative software in grounded theory research have been increasingly acknowledged (Corbin 2008; Seale 2005; Bringer et al. 2004; 2006). Within this study the researcher alternated between coding and analysis on the screen using NVivo and that with paper and pen, to ensure closeness to the data.

5.7 Data collection and analysis

Inductive and abductive approaches

In this study, data collection and analysis occurred in alternating sequences, as an iterative cycle between inductive and deductive approaches, known as abductive reasoning, depicted in Figure 11. In this process, the data that was collected from intensive interviews was then compared between results and new findings to further guide future data collection (Miles and Huberman 1994; Strauss and Corbin 1990).

Theoretical sampling continued until the point where theoretical saturation was achieved. Where, according to McCann and Clark (2003) theoretical saturation is reached when there is not any new emergent data relevant to specific categories and subcategories, categories have a conceptual density, and all of the differences in categories can be explained.

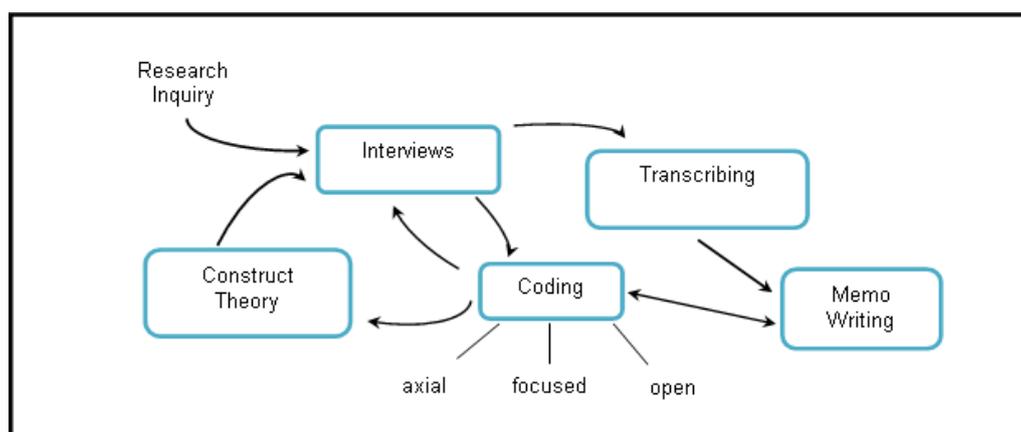


Figure 11: Abductive approach to data collection and analysis

Methods of data analysis

Coding

Participant observation

During overt participant observation, the researcher kept detailed observational notes, memos and reflective notes. All observational notes were transcribed, coded, and analysed using a coding paradigm, with data collection and analysis occurring simultaneously (Suddaby 2006).

As this phase of data collection was an immersive experience, codes and categories pertaining to culture, dynamics, power and conflict emerged in the open coding level. Axial coding began to reveal some of the categories, yet a main core phenomenon was yet to emerge that explained the potential synergy between wellbeing, public health and tourism. Thus, the next phase of data collection utilising the intensive interview method would need to address gaps in the development of the semi-structured interview guide.

In the first phase of data collection and analysis only pen, paper, and Microsoft Word were used. However, NVivo 10 was employed within the second phase of data collection due to the volume of data, this software package provided a means to efficiently organise data. Coding steps used within both phases of data collection follow the same iterative process and are detailed within section 5.8: data collection and analysis. All data collection and analysis drawn from participant observation was uploaded into NVivo 10 and collectively, with analysis from interviews, a substantive theory was developed.

Semi-structured interviews

Interviews were each transcribed and coded using computer assisted qualitative data analysis software (CAQDAS), NVivo 10. The process of grounded theory data analysis is a process of ongoing interplay between the researcher and the data (Strauss and Corbin 1990). The coding of interview data allowed the capture of what was in the interview data and further, learns how people made sense of their personal experiences. Coding represents the first step of data analysis and represents a process whereby there is a move away from particular statement to more abstract interpretations of the interview data (Charmaz 2006).

Strauss and Corbin (1990) suggest five main purposes of coding:

- 1) To build rather than test a theory
- 2) Provide researchers with analytic tools for handling masses of raw data
- 3) Assist analysts to consider alternative meanings of phenomenon
- 4) Are simultaneously systematic and creative
- 5) Identify, develop, and relate the concepts which are the building blocks of theory

Within grounded theory methodology, there are three main coding phases, open, axial and selective (Creswell 2007).

Open coding

The first phase of data coding occurred simultaneously to transcribing, where main categories were identified within the data through line-by-line coding. While there are many different ways that open coding can be approached, line by line analysis is advised to be one the most effective means (Charmaz 2009; Strauss and Corbin 1990), for researchers to remain open to participants' interpretations of what is important (Charmaz 2006). In this coding phase, several sensitising questions were posed to the data set including "Who are the actors involved?" What are the actors' definitions and meanings of the phenomena or situations?"

In this study, transcripts were analysed and each line labelled identifying when participants had raised key terms which included, "wellbeing meanings", "promoting wellbeing", "developing a wellbeing strategy" and "synergising wellbeing, public health and tourism". In this process, the researcher's role became clearer, as she selected the words that became the codes (Charmaz 2006).

In the review of data, the researcher adopted Charmaz's strategy of coding for actions rather than themes for example, "promoting wellbeing" or "managing a destination". The use of this approach that focused on actions enabled the development of new understandings about wellbeing and the evaluation of how they relate to the phenomenon of 'findings ways to engage with a healthy tourism offer'.

Axial coding

The next phase of coding relates categories to their subcategories, so called axial as coding takes place around the axis of a category, which links categories at property and dimension levels (Creswell 2007). Within this phase of coding the researcher identified the main open coding category of finding ways to engage with a healthy tourism offer, known as the core phenomenon, data was revisited to create categories around the core phenomenon. The use of diagramming within this study was fundamental to mapping the interrelationships between conceptual conditions (Strauss and Corbin 1990). As identified by Strauss and Corbin (1990), categories can include: causal conditions (causes of core phenomenon), strategies (actions taken in response to the core phenomenon), contextual and intervening conditions (situational factors that influence

the strategies), and strategies (situation events or factors influencing the phenomenon) (Creswell 2007). The result of this phase of coding is a visual model that relates the categories to the core phenomenon as represented in Figure 12.

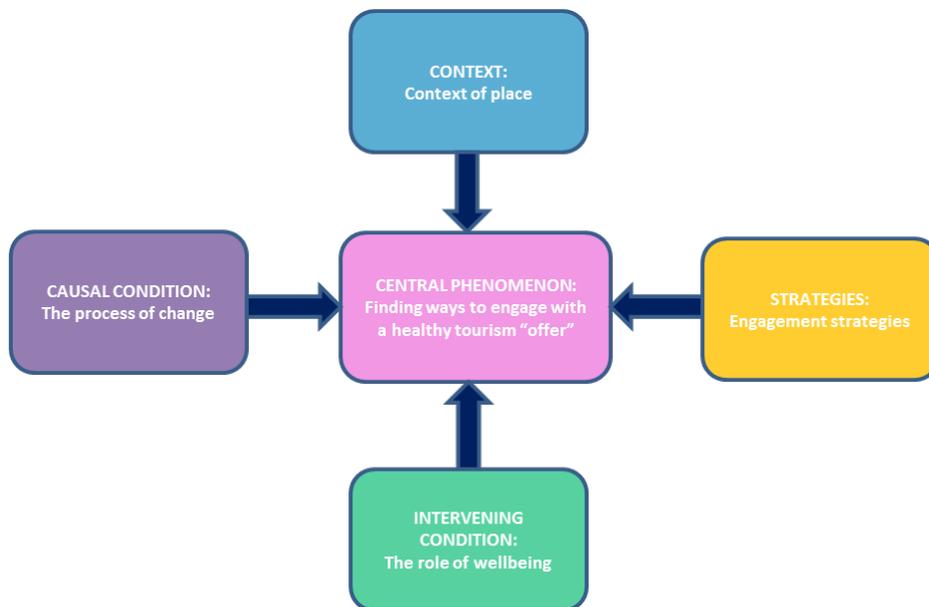


Figure 12: Visual model of the categories related to the central phenomenon

Selective/ focused coding

In the final coding step, the researcher used the axial model to develop propositions that interrelated categories to further develop a narrative describing the interrelationships in the model (Creswell 2007). Selective coding is the final coding phase, which seeks to integrate all the interpretation thus far completed within analysis phases (Scott 2004). In this coding phase, the researcher aimed to explain the storyline as it is linked to the central category (phenomenon) (Scott 2004). In this study, these codes were applied to a group of sentences and paragraphs where the most significant code was selected to encapsulate the interviewee’s voice. For example, focused codes illustrate participants’ perception of wellbeing meanings: “enhancing your quality of life,” and “nebulous is a good way to describe it.” Subsequently, this produced numerous codes which had to be condensed into major categories of: “interchangeable use of terms”, “individual wellbeing”, and “use in language”. This coding process helped to verify the suitability of the initial codes that were developed and were applied to subsequent interview transcripts.

Category development

Corbin and Strauss (1990) suggest that categories represent the cornerstones of developing a theory, where they provide a means to integrate theory. During the process of data analysis, hypotheses were developed among categories and were further developed during analysis. These were then used to approach field data collection where they were confirmed and revised as needed. In the process of coding, concepts such as the context of place, the role of wellbeing, the process of change and engagement strategies were identified, in grouping these concepts it became apparent, that each of these activities contributed to the understanding of finding ways to engage with a healthy tourism “offer”. Thus, concepts were first grouped under more abstract headings; however this abstract heading was not a category (Corbin and Strauss 1990). Categories were assigned properties and dimensions where the property represents a general or specific characteristic of a category, and the dimension signifies the locations of a property along a continuum (Strauss and Corbin 1998). Hence, a category was achieved when it was defined through its property and dimensions, the conditions that catalysed it, the action/interaction in how it is expressed, and the resulting consequences.

In this study, some of the subsequent questions that arose included:

- Under what conditions does someone use wellbeing strategies in their job tasks, and when not?
- What consequences arise from their utilisation?

Through this process of description, the categories within this study became more defined and were further given explanatory power. Repetition of this process allowed the researcher to see how categories were related to one another, which further lead to the formulation of a theory.

Core category

By discovering the core category, the researcher identified the central phenomenon of the study (Corbin and Strauss 1990). To identify the main category of finding ways to engage with a healthy tourism “offer”, the researcher asked some of the following questions of the data:

- What do the actions and interactions seem to be about?
- How is it possible to explain the main variations between and among categories?
- If I had to summarise my findings in a few sentences, what would I write?

The main role of the core category serves as a distinctive category which in turn summarises what is happening. Strauss and Corbin (1998) view categories as having analytic power because of their potential to both explain and predict.

Theoretical memos

Charmaz (2006) acknowledges the importance of memos in the development of a grounded theory as they allow the researcher to reflect on the data and explore different ideas. In this study, the research embedded memos within the data in NVivo to connect emerging ideas throughout the research journey. The use of memos was useful in further developing concepts within the processes of data collection and data analysis. For example, early memos explored ideas that included: challenges to wellbeing, wellbeing and being outdoors, wellbeing properties, and the impacts of interviewing on the researcher.

Sampling

Constant comparative approach

The constant comparative method embedded in grounded theory is proposed to be strict enough to guide the researcher in the exploration of content and meaning yet, not so rigid as to restrict the researcher (Hallberg 2006). Charmaz (2010) proposes a list of steps that are included in the constant comparative approach:

- (i) Comparing different people's views, actions, etc.;
- (ii) Comparing data from the same individual at different points in time;
- (iii) Comparing incident by incident;
- (iv) Comparing data categories;
- (v) Category with other categories.

Glaser and Strauss (1967) propose that comparative analysis may be used to generate two types of theory: substantive and formal. This study is concerned with substantive theory developed for a substantive (empirical) part of sociological inquiry; whereas formal theory is developed to contribute to a conceptual area of sociological inquiry.

The process of data analysis in this study, utilised the constant comparative approach whereby, when there was an event/situation acknowledged, it was then compared to other events/situations for similarities and differences. The main rationale for employing the constant comparative approach to data analysis were primarily to, mitigate researcher bias, achieve greater precision, i.e., grouping only like and like phenomena, and achieve greater consistency i.e., like phenomena always being grouped together (Corbin and Strauss 1990). The process of constant comparative analysis guided decisions that were made in regards to interview questions and an additional need for follow-up interviews with participants with knowledge about the intended area of study (Jeon 2004).

The role of the researcher in the analysis process

One of the key principles of constructivist grounded theory is that the researcher needs to adopt a reflexive approach and acknowledge their role in the emergence of the theory (Charmaz 2006). While the methods of grounded theory are considered to be neutral, the researcher is not, and plays a pivotal role within the coding processes identifying important data and naming categories and subcategories (Charmaz 2006). The constructivist approach enabled the researcher to constantly reflect upon their role while gathering and analysing data. In this approach the researcher is embedded in the study and the emergent theory is co-constructed by the researcher and the participants (Charmaz 2007).

Researcher's positionality

An important aspect of qualitative research is to consider and reflect on the researcher's role and how this may impact and shape the study. That said, the researcher's background will be outlined and reflected upon in regards to the impacts on the study. The researcher approached this study from an academic and professional background in sustainability and climate change mitigation. The subject areas of wellbeing, public health, and tourism were all relatively unknown concepts prior to the researcher engaging with this study. Additionally, the researcher had only recently arrived in the south of England to take up the research post from Edmonton, Alberta, Canada. Prior to accepting the research post at Bournemouth University, the researcher was working with the Office of Environment with the City of Edmonton's local government, as a Community Engagement Coordinator responsible for the reduction of community-wide carbon dioxide emissions. Prior to engaging with the research at Bournemouth University, the researcher had worked in the field of sustainability for over fourteen years. While the researcher had a great deal of experience in working in the public service, it was situated in a Canadian context and within the field of environmental sustainability.

In approaching this study, the researcher needed to acknowledge a limited amount of knowledge within wellbeing, public health, tourism or social sustainability. Additionally, the researcher did not have any pre-existing knowledge of the town that was being studied or the structure of the local government or public health department. In approaching the study, the researcher experienced levels of anxiety in being outside of their field of environmental sustainability and going from having a position of respect within a city's environmental community to be in the position of being an international student with limited resources. In turn, the researcher needed to accept their new role as a student, being a relative novice in the field and outside of their country with all previously held knowns and comforts.

Methodologically, the implications of the researcher's position on data collection, was that while she was not identifiable as an outsider visually (as the researcher is a white

female in her 40s) but, by an accent that would either be identified as Canadian or American. The researcher acknowledged that her role as outsider may have both positive and negative impacts the data collection process. Being an outsider may allow participants to be more open about their feelings about the organisational change, giving them a set of new person to share their concerns, thoughts and perspectives. The researcher also acknowledged that being an outsider with limited knowledge of process may make it difficult to engage and earn the trust of research participants. As an outsider, the researcher additionally acknowledged the challenge of understanding the British vernacular and regional accents and colloquialisms that would need to transcribed and analysed. In general, the researcher felt her position as an outsider led to a greater level of engagement with participants and a fuller immersion in the field component of the researcher. Participants were able to share ideas about their specific expertise without a concern that the researcher had a greater knowledge about their work area.

5.8 Constructing a theory

Substantive theory versus grand theory

A grounded theory is connected to the data from which it was generated, as it is grounded in the data. That said there are two main theories to be distinguished, a formal and a substantive theory. The purpose of substantive theories is to provide a theoretical interpretation or explication for a specific area thus, this type of theory is utilised for explaining/interpreting problems within a specific environment. It is contended that the majority of grounded theories, are substantive theories, as they focus on a particular substantive area (Charmaz 2006). Formal theories are viewed as being more abstract, providing a theoretical unpinning of a general issue that can be applied across a wide range of settings, concerns and problems (Strauss and Corbin 1998). This study seeks to construct a substantive theory, explaining the potential for synergies (social construction of meaning through interactions) within the specific context of wellbeing, public health and tourism.

There are different views about how substantive theories and formal theories are related to one another where, Charmaz (2006) proposes that through combining numerous substantive theories, a more formal theory can be developed.

5.9 Evaluation of the theory

Within qualitative research, there has been debate about the most appropriate criteria to use when evaluating these types of studies (Lincoln and Guba 2000; Morse et al. 2002; Miles and Huberman 1984). As the selected methodological approach for this study is constructivist grounded theory, Charmaz's (2014) evaluation criteria of: credibility,

originality, resonance and usefulness will be used to assess this constructivist grounded theory study. Credibility refers to the trustworthiness of the research process in general and includes: data presented, data analysis, evidence to support claims and the breadth of the data collected (Charmaz 20014). Originality is determined by whether the study identifies fresh insights, extending upon the existing knowledge in the field of study. Resonance is the assessment of both the breadth and depth of the data and if the categories were saturated. Usefulness of the study is determined by the relevance and contribution to existing knowledge base and the substantive research area Charmaz 2014).

Denzin and Lincoln (2000) suggest that theories constructed using grounded theory methodology do not fit well with the traditional positivist evaluative criteria of bias, validity, generalizability and reliability. That said, the final stages of validity, reliability, and credibility took place in the ongoing submission of dissertation chapters, where outside reviewers are invited to judge the quality of the grounded theory study (Strauss & Corbin 1990). Strauss and Corbin (1990), also outline the criteria by which the quality of a grounded theory may be evaluated.

These criteria represent a benchmark for assessing the quality of the grounding of the study in the data (Creswell 1998). Where, Landis (1993) both listed these standards and used the criteria to assess her study. Other guidelines for evaluating a grounding of theory in the data include Glaser's (1978) criterion of: fit, work, relevance, and modifiability. Charmaz (2005; 2006) proposes that there are four main criteria of evaluation: credibility, originality, resonance, and usefulness. Under each of these criteria headings Charmaz has developed a list of questions for the researcher to consider in their grounded theory analysis and theory development.

Within this constructivist study both Strauss and Corbin's (1990), Table 5, evaluative method and Charmaz's (2006) evaluation based upon questions of credibility, originality, resonance and usefulness were employed to assess the quality of the constructed theory, these questions are listed within Appendix 4.

Criteria for methodological rigour

Criteria	Evaluative Question
Criteria #1	Are concepts produced?
Criteria #2	Are the concepts systematically related?
Criteria #3	Are there many conceptual linkages. And are the categories well developed? With density?
Criteria #4	Is there much variation that has been built into the theory?
Criteria #5	Are the broader conditions built into its explanation?
Criteria #6	Has process been taken into account?

Table 6: Proposed criteria for judging the empirical grounding in the study (Adapted from Strauss and Corbin 1990)

5.10 Generalisability, Transferability and Reproducibility

Generalisability

Glaser (2004) suggests that all substantive grounded theories have general implications that extend past the local population studied within the research. Grounded theory does not seek to achieve descriptive transferability rather; it offers conceptual generality, where the theoretical findings will have relevance across other intra-organisational synergies through boundary objects, as well as into other broad areas. Grounded theory methodology facilitates the construction of a substantive theory directly relevant to the substantive area from which it emerged. As such, the constructed grounded theory will have a conceptual generality.

Corbin and Strauss (1990) contend that generalisability of a grounded theory can be achieved through abstraction, a process which occurs over the entirety of the research. It is further suggested that concepts and core categories with higher levels of abstraction have greater theoretical applicability. Additionally, a grounded theory specifies under what conditions the selected phenomenon has been uncovered within the data set. Thus, the situations that do apply are meticulously specified. It is also put forward that a grounded theory may be generalisable as it delineates the conditions that are connected to action/interaction to related sets of consequences. It is argued that the more systematic and wide ranging the theoretical sampling, the greater the number of conditions and variations that will be uncovered and the generalisability, precision, and predictive capacity of the given theory (Corbin and Strauss 1990).

In practice, it is advised, that the utilization of a theory may meet a marginally similar situation and practitioners may opt to still have the theory guide action (Corbin and Strauss 1990). Therefore, it is indicated that the specific application of a theory depends upon how it qualifies to meet particular situations.

Transferability

Research indicates that findings are both generalizable (Morse 1999) and transferable (Malterud 2001) to other contexts evaluating potential intra-organisational synergies (substantive area). Broadly, Lincoln and Guba (1985) suggest that qualitative researchers discuss the transferability versus the generalizability of findings. Transferability refers to applying study findings to similar contexts to that where they were first derived (Henwood and Pidgeon 1992). However, it would appear that there is greater evidence to support generalisability versus transferability. That said, it is contended that the transferability of the findings cannot be specified by the researcher, who can merely provide sufficient information, it is then up to the reader to determine whether the findings are applicable to a new situation (Lincoln and Guba 1985).

Reproducibility

Reproducibility indicates that in the case where there is the same theoretical perspective, procedure for gathering and analysing data, a researcher ought to be able to develop a comparable theoretical explication of the phenomenon (Strauss and Corbin 1998). Corbin and Strauss (1990) reveal that a grounded theory may be reproducible only in respect to it being verifiable. However, it is acknowledged that there is not a high likelihood of a theory that deals with social psychological phenomenon, being reproducible.

5.11 Conclusion

This chapter has described the research design for this study using constructivist grounded theory methodology to best achieve the study aim and objectives. The two phases of research were each described to provide a transparent account of the iterative, abductive approach utilised for data collection and analysis processes. Coding steps revealed how categories were developed and further saturated to arrive at the construction of substantive theory, explaining the potential factors and processes influencing synergies between wellbeing, public health and tourism. The data collection and analysis steps here described led to the construction of a substantive theory explaining how engagement experiences and processes contribute to the construction of meanings and ultimately the potential for synergies between wellbeing, public health

and tourism. The next five chapters will present the findings and discussions drawn from data collection and analysis.

6. FINDINGS AND DISCUSSION: THE PROCESS OF CHANGE

6.1 Introduction

This findings and discussion chapter is the first of five inter-related findings and discussion chapters which are connected by a central phenomenon or core category. Together they provide an explanatory theory of the means to achieve synergy between wellbeing, public health and tourism. Similar to the tradition of past qualitative studies, the findings and discussion will be presented together in each of the next five chapters (Holloway and Brown 2016; Richards and Morse 2012). Chapter 6 will examine the **process of change** as a causal condition to promoting the central phenomenon. Chapter 7 will assess the intervening conditions related to the **role of wellbeing**. Next, the contextual considerations will be examined in chapter 8 that focus on the theme of **the context of place**. Chapter 9 will discuss findings that relate to the **engagement strategies** that contribute to achieving the study's central phenomenon. Finally, chapter 10 will examine the central phenomenon of **finding ways to engage with a healthy tourism "offer"** and reveal the interrelationships to all of the categories within an explanatory theoretical model.

This chapter seeks to explain the **process of change** that resulted from the public health agenda moving to the local authorities and how it may provide conditions to synergise the concept of wellbeing and local public health and tourism departments. Study data includes participant observation and semi-structured interviews with members from public health and tourism departments working within a local authority, in a town on the south coast of England. Participant observation occurred prior to the move of the public health agenda to the local authority between January and September 2012. Sixteen interviews were conducted with local council public health and tourism team members five months after public health moved into the local council, between September and October 2013. To ensure confidentiality, all participants' names have been replaced with self-selected pseudonyms, which are used throughout this study.

All study data was coded using an organising scheme (coding paradigm) that focused on: the **conditions**, the circumstances and situations that form the structure of the studied phenomenon; **actions/interactions**, participants' routine or strategic responses to issues, events or problems; and **consequences** the outcomes of the studied actions and interactions. The aim of this chapter is to address the following questions:

- What engagement experiences contributed to synergies between wellbeing public health and tourism?
- What caused these engagement experiences?

The chapter framework is illustrated within Figure 13: framework for the process of change chapter. This serves as an outline for the chapter illustrating the main categories and subcategories and the order that they will be discussed. Within the structure of this chapter, category and sub-category names were derived from both in vivo codes and co-constructed themes that emerged from the data. This chapter's framework for analysis serves as a route to identify salient properties and dimensions associated with the process of change category and related sub-categories, with the ultimate aim of increasing the explanatory power of the theory.

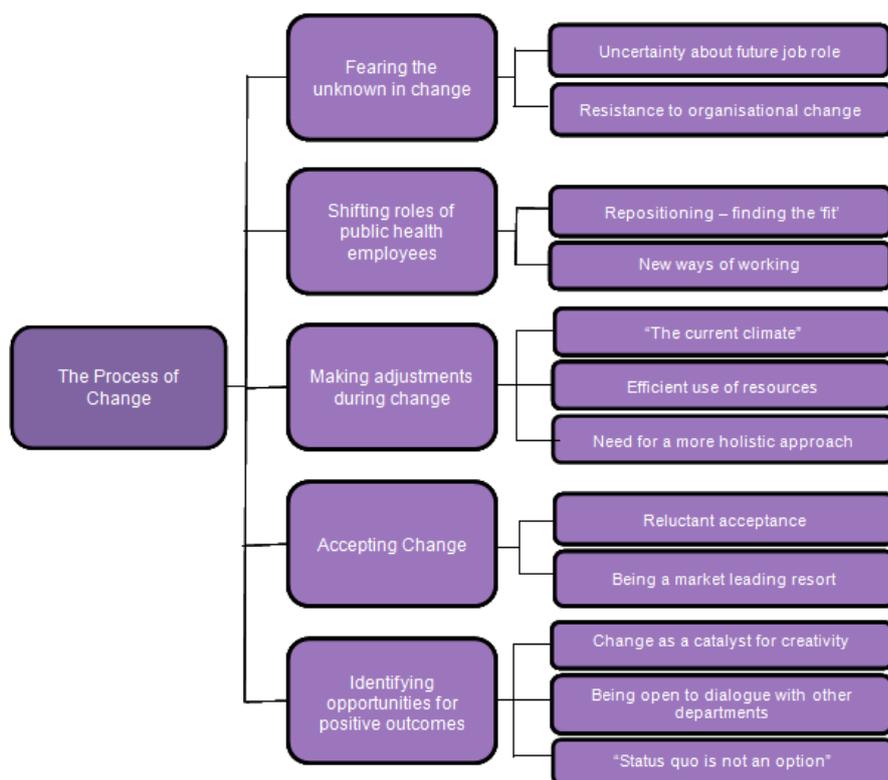


Figure 13: Framework for the process of change chapter

6.2 Fearing the unknown in change

Uncertainty about future job role

Applying for posts within the new public health structure

Prior to the move of the public health team to local authorities, there were high levels of fear, uncertainty and tension observed in the months leading up to the change. The nature of participants' conversations and interactions revealed high levels of uncertainty about what the future may hold for the team, the organisational structure and for

individual job roles and responsibilities. Observational notes revealed that much of the team's time and energy was spent preparing for the upcoming transition, with team meetings focused on preparing the current staff for the eventuality of applying to new posts across the conurbation. Much of these observed tensions could have been explained by the lack of job certainty with the upcoming reorganisation. While there were varying levels of tension observed across the team, one of the most commonly identified stressors was around job uncertainty.

The concept of uncertainty has been defined as the perceived inability to accurately predict something (Milliken 1987), which does accurately capture how public health team members were feeling during their transition. Similar to observations within the public health team, organisational change research suggests that uncertainty is frequently a central concern for employees (Bordia et al. 2004; Schweiger and Denisi 1991; Ashford 1988). In addition, much research has acknowledged the role of uncertainty and the related negative impacts on psychological wellbeing (Pollard 2001; Maurier and Northcott 2000; DiFonzo and Bordia 1998).

Furthermore, numerous studies have shown that during a merger, akin to public health moving into the local authority, employees experience uncertainty around the structure of the merged organisation, the impact of the merger on their work team and the probable changes to their job role (Terry et al. 1996; Buono and Bowditch 1989). Bordia and colleagues (2004) additionally indicate that uncertainty may be experienced in regards to both job security and about future roles and responsibilities. As was the case with the organisational change with public health, organisational restructuring typically involves merging of teams, dissolution of inefficient units, and team reformation. In turn, these changes lead to uncertainty about pecking order, status of work units, and policies and practice (Buono and Bowditch 1989).

During change within an organisation, literature highlights that employees' uncertainty may be due to a number of organisational issues including: the rationale behind the change, the process of implementation, and the anticipated outcomes of the change (Buono and Bowditch 1989). Research proposes that this inability to predict events can be ascribed to vague (Putnam and Sorenson 1982), contradictory or deficient information (Berger and Calabrese 1975). Research identifies one of the main features of uncertainty to be related to a sense of doubt regarding future events or cause and effect relationships within the environment (DiFonzo and Bordia 1998). Evidence from this study revealed large levels of doubt and it was observed that there was contradictory and vague information presented through formal and informal networks, regarding future job roles and organisational structure.

Levels of organisational uncertainty

Organisational uncertainty has often been conceptualised at three levels: organisational (strategic); group (structural) and individual (job-related) (Bordia and Hobman 2004; Jackson et al. 1987). Organisational-level issues include rationale for change, future direction of the organisation, and its related sustainability (Bordia and Hobman 2004). Similar to noted observations, Desveaux (1994) contends that changes in government lead to uncertainty amongst public service employees in regards to the impact of changing policies and the organisation's strategic path. It is further proposed that uncertainty is due to ambiguous vision or strategic direction put forward by change leaders (Kotter 1996). Evidence from this study would also confirm that uncertainty was operating at different levels, as there were several unknowns that employees were challenged to cope with on a daily basis.

However, the greatest observed level of uncertainty seemed to centre on job-related uncertainty, as there seemed to be many unknowns about the future of presently held positions. Job-related uncertainty during organisational change has been comprehensively researched in past studies (Ito and Brotheridge 2001; Maurier and Northcott 2000; DiFonzo and Bordia 1998) and has been connected to job security, advancement opportunities, and job role changes (Bordia et al. 2004).

Mechanisms to cope with uncertainty

Traditionally, it has been acknowledged that the state of uncertainty motivates people to engage in coping mechanisms to minimise these perceptions (Bordia and Hobman 2004; Berger and Bradac 1982). The uncertainty reduction theory (Kramer 1999; Berger and Calabrese 1975) suggests that when uncertainty is experienced, employees are driven to acquire information aimed at reducing this state (Allen et al. 2013). The uncertainty management theory provides an alternative conceptual frame, which argues that the perception of uncertainty may be perceived in a positive light within certain contexts (Brasher 2001). It is further contended, that within health contexts, information-seeking behaviours may be utilised to reduce feelings of uncertainty and increase optimism and hope (Brasher et al. 2002).

In meetings attended by the researcher, the uncertainty reduction theory would seem to explain many of the interactions observed within team meetings. For example, the majority of questions in meetings focused on information acquisition, which appeared to result from the levels of uncertainty that emerged from a lack of communication (or information) provided by senior levels by management. Team meetings provided a forum for employees to ask, often pointed, questions about the direction of the public health agenda, the new proposed structure, and the future of current job roles. While these meetings did maintain a level of professionalism, some of the questions directed at senior management seemed to be interrogatory. It would seem that at some levels,

communication and interactions fell in line with organisational management theory: when employees' perceived that their job loss was imminent, they would seek information that would make this conclusion less certain, thus, cultivating uncertainty (Bradac 2001).

Maintaining a calm demeanor

A key observation about the culture of the public health organisation prior to the move, was that behaviours, during this potentially tense transition period, seemed quite calm and a business as usual approach was maintained within the department. This observation may both have been a facet of not showing emotion to an outsider and or it being part of the British culture, as observations were made from the observer's Canadian socio-cultural perspective. There were signs, however, of something bubbling under the surface, as team members working within an open office environment, would on occasion, have episodes of bickering, showing signs of internal strife. These incidents were not frequent yet the emotion shown did not seem warranted within the context of each of the situations, thus suggesting that there were underlying rationale for the behaviour. Additionally, there were meetings that the researcher was asked to not attend - the reasons given were that things may get quite heated and emotional, thus it not being a healthy environment for the researcher. In addition, team members would confide in the researcher about the challenges they had with some of their team members, or about their dislike with how certain public health issues were being managed. These events cumulatively revealed some of the different ways that public health employees coped with the stress associated with high levels of uncertainty.

Extant literature has noted several negative outcomes related to organisational uncertainty which include: stress (Pollard 2001; Ashford 1998); diminished job satisfaction (Nelson et al. 1995; Ashford et al 1989), commitment (Hui and Lee 2000), and trust in the organisation (Schweiger and Denisi 1991). These negative consequences of uncertainty arise from the corresponding feeling of a lack of control (DiFonzo and Bordia 2002; Lazarus and Folkman 1984). This noted stress and lack of control was evidenced through both observational and interview findings, where coping mechanisms were primarily information seeking and diversifying options. Research affirms that stress in work situations is linked to low motivation and morale, low job satisfaction, and poor internal communication and conflicts (Schabracq and Cooper 2000; Murphy 1995). The findings within this study being consistent with the reviewed uncertainty and stress research related to organisational change.

Resistance to organisational changes

Questioning the value of the public health move

In the analysis of interview and observational data, it was noted on several occasions that the shifting of public health into the local authority was something that had already been tried in the past and as a result, there was generally either a resistance or apathy with regards to change. Some of the participants' interviewed wondered about the real value of the move and wondered whether it would ultimately make any sort of difference, leading a public health participant to remark:

"But we go around in circles with these things don't we because public health used to be part of local authorities, then it was taken out to health, now it's gone back to local authorities, be interesting to see whether it does make a difference really" (Evie)

In addition to resistance to the change process in general, there was also resistance to moving to the local authority. Past research asserts that when confronted with a significant organisational change, employees go through a reaction process (Jacobs 1995; Kyle 1993) that is comprised of four phases: initial denial, resistance, gradual exploration and eventual commitment (Jaffe 1988). The reaction of resistance to the organisational change and move specifically, was observed on many occasions and was aptly captured by Ethan (Public Health) who recalled the emotional climate in the public health team prior to their transition to the local authority:

"because you go through all of this structural upheaval of change and people get really down about it and a lot of public health people coming out of the NHS (National Health Service) were a little bit doom and gloom about what the future held and oh it's going to be a terrible being with the local authorities" (Ethan)

Within organisational change research, resistance is viewed to be a natural part of the change process that can actually be anticipated (Coghlan 1993; Steinburg 1992). Past findings contend that the main reason for resistance is due to the change from a known to an unknown state (Coghlan 1993; Steinburg 1992). It is further suggested that resistance to change may result when employees have a fear of losing something meaningful during organisational change (Kotter and Schlesinger 1979). These could include: security and stability (Chreim 2006; Ugboro 2006); status (Proctor and Doukakis 2003); or competence and self-efficacy (Chreim 2006). The evidence from this study revealed resistance amongst the majority of the participants within the public health team, which seemed to stem from the mounting number of unknowns associated with future scenarios. Additionally, as public health had a particular organisational culture, some of the resistance may have been connected to the fear of losing a known dynamic and way of doing things, which runs parallel to existing research findings.

Considering the phases of change

Past literature tends to focus on the implementation of the change process, rooted in Lewin's (1947) change model, where there is a progression through the phases of

unfreezing, moving, and freezing. In situating findings from this study within change theory, adaptations to Lewin's (1951) three phase model of change 'unfreezing, moving, and refreezing' seem to bear resemblance. In more recent adaptations, Armenakis and colleagues (1999) have proposed two models, both patterned after Lewin's (1947) change model, the first addressing readiness for change and the second focused on the institutionalisation of organisational change.

The first of the models, the readiness model focuses on the role of the change agents in driving change, local and horizontal change agents. The evidence drawn from interviews with the public health team indicate that the transition phase prior to the move involved elements associated with unfreezing. Armenakis et al. (2011) suggest that there are several reasons why some individuals will welcome change and others will not, which may include: personal characteristics and social discriminates. That said, reactions to organisational change will not be even, further prompting the recommendation that this ought to be a consideration when crafting messages (Armenakis et al 2003).

The second model explores the stages through which change targets progress (Armenakis and Bedeian 1999). It would seem that the change process regarding public health prior to moving to local government was in the first stage of the process, where there were oscillations between resistance and anticipation. During the period six months after the move, there seemed to be elements from both phases and stages of the change process evident, as shown in Figure 14. For example, there was evidence that fit within the unfreezing and moving phases and denial/resistance and exploration stages.

After the move of public health to the local authority there was some resistance, more notably by members of cabinet and tourism staff. Within these groups, there seemed to be a fair amount of apprehension to public health being part of council business. In one of the introductory sessions, public health employees reported meeting resistance from members of council. They recounted that after an introductory statement by the public health team, a councillor stood up and declared that they were not prepared to do anything that would potentially lose them votes. Reflecting upon public health's introductory session with the local authority, Mia shares her views:

"We are adding value you know, and reporting if the initiatives are good value or not. But, it's a fine line because if it loses them votes at the end of the day" (Mia)

This situation illustrates part of the complexity involved in the change process and the types of resistance amongst council members. It is argued that to successfully lead an organisation through change requires balancing human and organisational needs (Spiker and Lesser 1995; Ackerman 1986). In turn, it is suggested that as organisations are comprised of people, organisational change necessarily involves individual level change (Band 1995; Steinburg 1995). Within this stage of exploration, the majority of

participants recognised the need to find a balance or fit within the scope of changing budgets, agendas and roles.

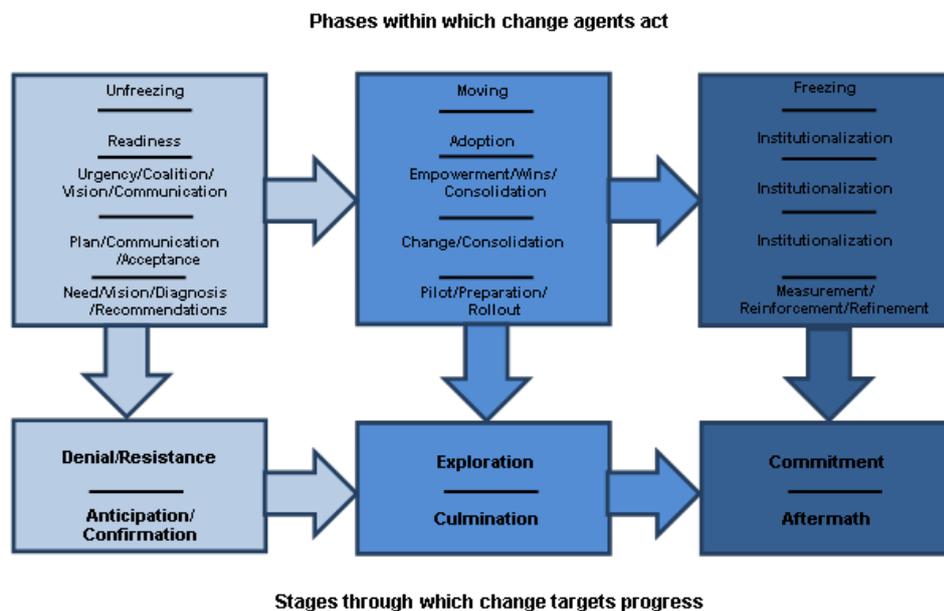


Figure 14: Change agent phases and change target phases (Amenakis and Bedeian 1999)

6.3 Shifting roles of public health employees

Repositioning – finding the fit

Transferring the health and wellbeing agenda to the local authority

In evidence from interviews conducted after the move of public health to local authorities, many of the interviewees, both within public health and tourism, spoke about the changing role of public health within local government and alluded to the ripple effects across the organisation. A recurring mention among participants was around where public health and the health and wellbeing agenda ‘fit’ within the structure and function of local government. It seemed that the two main concerns regarded the nature of the new health and wellbeing agenda and where that agenda fit within the current organisation. One public health team member described the process of understanding the general transference of a ‘health and wellbeing agenda’ to local authorities:

“So up until the 31st of March public health was in the public health service, 1st of April it moved to local authority and a transfer of certain agendas into the local authority. So those are the key national agendas for which money has been set aside to do those things....So there were some very specific agendas that transferred for public health known as mandatory programmes so one is around drug and alcohol, one is around sexual health and one is around something called

health checks and one is around the national child measurement programmes”
(Daniel)

Interview findings revealed much about the context of public health agenda and budget transference. The repositioning of public health was associated with the transference of both agendas and budgets but, as evidence suggests, money was only set aside for select national agendas. Therefore, in the alignment of priorities the mention of budgets and the public health budget being ‘ring-fenced’ was an area where there was a lack of clarity (or disclosure), amongst all participants. It became evident through analysis, that many of the study participants seemed unclear about the specifics of the new health agenda and there was some concern about the transfer of budgets and resources.

Positioning public health in local government structure

In terms of repositioning, not only was public health finding the fit of its agenda within the local government organisation, there was also the positioning of cabinet members and where health fit within current portfolios held. Within the local context of this study, public health was positioned with the portfolio holder overseeing issues that include health inequalities and regeneration. In addition, the public health portfolio holder spoke about the role of boards guiding the transition and potential synergies. The established health and wellbeing board seemed to have an increasingly significant role, given the number of times it was mentioned through the interview process. In terms of cabinet member repositioning, participants reported that their portfolios were changing right up to the actual April 1st move to local authority. Lucy (Public Health) reveals her thoughts about the role of public health in the context of the health and wellbeing board. In addition, Ethan, a public health employee shares his feelings about the current positioning of the public health team:

“I think because public health has only very recently come into the local authority...and..now I am sitting on the joint public health board and the health and wellbeing board has been set up to oversee the new relationship and synergy that is going on with local authorities, it’s beginning to be used more.” (Lucy)

“[public health] is now more closely aligned with regeneration which I think is due to inequalities, which is no bad place to be” (Ethan)

These interview threads, highlight examples of more positive reactions to the move of the public health agenda and areas for potential synergy. Extant literature emphasises the role of organisational change as an immense stressor within organisational life and is often associated with unfavourable results that include, job loss, reduced status, and threats to an individual’s psychological wellbeing (Schweiger and DeNisi 1991; Ashford 1988). Furthermore, past findings also indicate that individuals with an internal locus of control are less prone to incurring the ill effects of stressors (Lau and Woodman 1995; Newton and Keenan 1990).

The study evidence revealed the different reactions and coping mechanisms used by local government employees, where some employees were fairly optimistic about the potential outcomes associated with change and others were a little more cautious, which echoes findings within reviewed literature. Past research refers to these reactions to change as 'team member adaptivity' which refers to the amount that individuals cope with, respond to or support the changes which impact their roles within a team (Griffin et al. 2007). Capable adaptability is noted to influence performance (Moon et al. 2004).

New “ways of working”

Re-positioning public health roles

In terms of the positioning of public health within the structure of the local authority and the conurbation, many participants mentioned the split in their new job roles between working half-time within a local authority office and at the county office half-time. This geographic positioning of roles with public health also impacted the areas and levels of responsibility. In the analysis of individual level job responsibility there were noted changes in areas of responsibility, as compared with the management of public health prior to the move to local authorities. Mia and Isabella each share their interpretations of their new roles:

“So I have 50% head of health protection programmes and 50% public health support in [the local community]. So that’s quite a different role, that’s more generic, so it spans all of public health and its obviously more about working with the local community. Whereas my head of the health protection programmes is more about the whole of the [county] population” (Mia)

“We are actually commissioners of services, I think that’s probably the distinct difference between how public health used to be which was very much providing hands to commissioning or decommissioning services. Now, it’s all about contracts and money and effectiveness which is always a good thing... so my role has changed from commissioning services to scrutinising the effectiveness.” (Mia)

“So..i started in March this year it’s really a result of the transition. A result of the PCT (Primary Care Trusts) disbanding, public health coming over to local authorities. Public health inherited a new set of responsibilities, a slightly different way of working.” (Isabella)

“So we’ve inherited a range of contracts, from the PCT and within those contracts, there’s a great deal of work in trying to unpick and understand what those contracts are. How much they are funded? What they are currently delivering on? Because some of these contracts weren’t held by us, they were held by, the PCT. So it’s to understand some of the new stuff about that. It’s to identify opportunities to achieve improved effectiveness of the services that we commission, to improve efficiencies, a huge scope for that.” (Isabella)

This evidence highlights that the way in which public health operated in the past, is now in the process of being scrutinized, where those employees formerly carrying out contracts, are now scrutinising the delivery of related services. Some of the interview findings indicated that there was a range of doubt about the effectiveness of new levels of responsibility and their value within the local authority as a whole.

Whilst there may have been a level of doubt, evidence also suggests that participants perceived the move of public health to local authority as an opportunity for greater effectiveness, both in terms of cost savings and organisational efficiencies. While each participant seemed to frame this new responsibility as an opportunity to positively affect change within the organisation, it was by no means described as a simple or straightforward task. Similarly, Richards (2003) suggests that much of public sector reform has involved giving managers more strategic efficiency-oriented responsibility. Laffin and Entwistle (2000) stress that these changes to levels of responsibility have been suggested to impact the status and influence of the professional, whose expertise may no longer be deemed as valuable (Laffin and Entwistle 2000). Evidence from this study revealed that perceived value seemed to still be at an indeterminate state, within the given stage of transition or change.

“Legally all of our responsibility”

In finding new ways of working, members of the public health team spoke about means of adapting and crafting levels of responsibility for health within local government. At a strategic level, public health levers were finding their fit within local government’s responsibilities, where Ethan conveys one approach:

“So what I’ve been clear about is just how much the council’s already influencing opportunities to improve health and wellbeing. So you take the whole breadth of levers available, provisions of early years um..influence over schools, the 0 to 5 environment – you know, council’s commissioned all of those services and they’ve got a fantastic ability, if you like, to shape that environment and they’ve been doing that for many years. I think while it’s going to take time, I think that’s really about handing over responsibility to the officers to say we are all the council and it’s legally all of our responsibility now to improve the health and wellbeing of residents...So don’t ask me what I am going to do to improve the health of the residents, I’ll be asking you what we’re going to do to improve the health of residents because lots of the levers and opportunities rest with the officers that you manage and the decisions that obviously your councillors are taking which influence and affect the town.” (Ethan)

The evidence cited above, highlights the importance of revealing the value of public health within local government and how there is a need for health responsibility to be realised across the organisation as a whole, as opposed to it being the responsibility solely of one department. This message was consistently mentioned by members of the

health team, who shared examples of ways to change perceptions within the organisation. Mia emphasises the importance of conveying the public health value to council members at the onset:

“I think it is our job to brief these members, particularly the member who has got the portfolio for public health so they understand really well what we are about and that...we are adding value you know and that the initiatives are good value or not” (Mia)

Among tourism employees it was also recognised that the responsibility for health was now resting with the local authority where there was mention of some of the potential implications for the tourism department. Jayden shares his perspective about the health context and local government:

“Um...and because the local authority’s got the responsibility for healthcare generally in the area pushed back, it’s going to come to the fore. But even before that we were very keen to work at looking at ways what we could help the [destination] to become a healthier option, a healthier choice” (Jayden)

In this example, Jayden, a member of the local tourism team indicates how there was an interest in creating a healthier destination before the shift of the public health agenda to the local authority. Similarly, findings drawn from interviews with other members of the tourism team highlighted some of the parallel interests to the public health team in diversifying the tourism offer, to provide wellbeing activities for populations that do not currently use the coastal area. These provide examples of areas of synergy for the concept of wellbeing and public health and tourism communities of practice.

6.4 Making adjustments during change

“The current climate”

Impacts of the economic recession

The analysis of interview data revealed that there were many “tuning problems” recognised in relation to organisational change in the context of: the economic climate, balancing of resources, and knowledge silos. The economic climate and economic recession was one of the contextual factors that were frequently mentioned by participants, when discussing their thoughts about organisational change. The potential for negative implications were cited by Logan with the tourism team, who connected the economic climate with increasing levels of stress:

“And particularly when you’ve had an economic recession like we’ve had over the last four or five years, you find that they reduce costs by adding and spreading workloads and some people pick up huge amounts of work load and carry that and I think that just builds stress.” (Logan)

Local government spending

Organisational change within the public service was also noted by participants as being connected to local politics and financial pressures, where Mia contends:

“Sometimes trying to balance effective public health with politics within the local government, particularly in the current climate again huge pressure financially, they have to make big saving. I am not sure the two will go hand in hand. There is a lot of sensitivity around this...” (Mia, Public Health)

Past change literature also highlights political constraints that exist within public sector organisations which in turn have prevented managers from pursuing organisational goals (Day and Klein 1987). Additionally, Perry and Rainey (1988) note that public sector organisations are often motivated more by political concerns. In the case of public health moving to local government, the politics within the local authority were noted by participants, to be areas of both alignment and contention.

Efficient use of resources

“Tuning problems”

Contextually one of the challenges acknowledged within the public health team was around clearly defining the county level and local levels of accountability. In separating out the different areas of responsibility, cabinet members shared their perception of the challenge:

“But that’s where there is a whole geographic county combining for our public health board but we have specific local delivery because we’re accountable locally.” (Jacob)

“Because health is going through a lot of changes not all of them assisted by government, it’s fair to say, and those changes mean that we have to be very careful to get our fair share of resources for our fair share of responsibilities. And that transition is going reasonably well but obviously there are a few tuning problems and that’s where things like the health and wellbeing boards are set up to clear these issues.” (Joshua)

Evaluating service efficiencies

Politically, one of the most notable challenges is around the efficient use of resources, where the words efficiency and effectiveness were echoed at all levels within the local authority. In addition, much of the concern voiced about the change through-out the interviews was about the use of resources, which is exemplified in Jacob’s voiced concern about the evaluation of effectiveness. One of the examples provided was around the role of the health and wellbeing board in evaluating effectiveness:

“The health and wellbeing board through the NHS are starting to question whether, because a lot of the NHS contracts have transferred over to the local authority so we need to do our own evaluations to see if they’ve been successful and delivered what they’ve, we meant to.” (Jacob)

From another perspective, a public health employee made a comment regarding the potential for resources to be used towards health promotion or prevention within the local authority:

“And hopefully taking it out of health and putting it with local authorities means that there will be a more strategic push to improve public health and use the resources for that instead of it being so soaked up by all the problem issues”
(Evie)

Research suggests that leading an organisation through change includes the balancing of human and organisational needs (Spiker and Lesser 1995; Ackerman 1986). In the case of evidence gathered within the context of the local authority it would seem that at present there is a preferencing of organisational needs as they relate to financial versus human capital. This is not to imply that this will always be the case, yet it would seem that within the transition of the public health agenda, one of the greatest concerns is around finding the most effective use of financial resources. One of the cautions, prominently noted within organisational change literature, focuses on the means necessary for achieving organisational innovation where noted constraints are stability in both thought and action (Dougherty and Heller 1994).

Need for a more “holistic” approach

Many study participants acknowledged the challenge of vertical and horizontal knowledge silos to resource use. Logan, a tourism associate discusses his thoughts about the challenges to organisational collaboration or synergy:

“The way the system works makes people think in terms of their own responsibilities and their own patch. Whereas what you need is a holistic view whether that is to development or planning or regulations or whatever. And because we are used to being in departments..we look after our own department, it doesn’t utilise the best of the resources in terms of achieving the overall objective. You can have lots of departments running well and efficiently and not achieve what you want to achieve” (Logan)

Jack with the tourism team underscored this point from another perspective, where on the one hand conversations could be beneficial across portfolio boundaries, he alluded to a worry that it may interfere or undermine the current position-holder’s role and associated vision:

“Unfortunately since I have taken on this totally different portfolio, I see the portfolio holder and we chat but I never ask what’s happening frankly because it sounds like interference and I don’t want to do that. [They are] part of the portfolio now it’s [their] baby now not mine. I have enough problems with my own” (Jack)

Past research increasingly highlights that one of the biggest challenges for contemporary governments is to resolve complex social problems which continue to threaten communities (Keast et al. 2004; Clarke and Stewart 1997). These issues remain a

challenge as they cut across policy and service areas, often defying solutions presented through a silo approach (Mitchell and Shortell 2000; Pearson 1999). It is further noted that traditional ways of working have led to an increase in fragmentation of both people and services (Funnel 2001; Clarke and Stewart 1997).

Barriers to knowledge sharing or knowledge silos are noted to be common to organisations of all types (Ardichvili et al. 2003). Additionally, it is contended that within the public sector there are also professional silos which have impeded public organisations from working well together (Hackney and McBride 1995). It is warned that whether organisational barriers are vertical or horizontal, the existence of knowledge silos, can have solemn consequences (Contu and Willmott 2003).

While knowledge sharing and management are not new concepts, they are slow to being realised in the public sector (Bundred 2010). Further it is contended that effective knowledge sharing results from dedicated leadership and the correct organisational culture (Bundred 2010). In terms of staff interest in knowledge sharing, if holding a position, or promotion, or finding new positions rests on your knowledge – where is the incentive to share knowledge (Currie and Kerrin 2004; Wilson 2002)?

Past research refers to these reactions to change as team member adaptivity which refers to the amount that individuals cope with, respond to or support the changes which impact their roles within a team (Griffin et al. 2007). Capable adaptability is noted to influence performance (Moon et al. 2004). Individual differences in perception and coping around organisation change impact the ultimate success and levels of approval, which are explored in the next section.

6.5 Accepting change

Reluctant acceptance

“Changes happening all the time”

Study data revealed that many participants were reluctant to accept or commit to organisational change as it seemed to be happening all the time. Mia and Isabella, both from the public health team shares examples of how things seem to be continually changing within their work environments:

*“So there’s a lot of people....who’ve gone to public health London and thinking, I don’t want to do this because I am limiting my speciality too much so they are coming back to the local authorities, so we have not bedded down yet, at all.”
(Mia)*

“It’s slowly evolving and there’s changes happening all the time. You know starting with practical issues like they didn’t have a full complement of staff, they haven’t been able to recruit staff.....” (Isabella)

McGuinness and Morgan (2005) contend that change is prevalent and in turn is a regular part of organisational life, not just a rare phenomenon. Thus, employees, managers, and leaders are continually adapting to change, with ever-refined effectiveness (Pfeiffer et al. 2005). Additionally the majority of change conceptualisations incorporate the notion that it is an ongoing process (Armenakis and Bedeian 1999). Mack et al. (1998) emphasize the fluid nature of organisational change which does not fit the traditional model of change comprised of unfreezing-moving-refreezing model (Lewin 1947), suggesting that employees in today's work climate do not experience change in such a simple sequence. Conversely, employees seem to be in a constant state of uncertainty where they do not reach a refreezing. In a similar vein, Callan (1993) advises that ongoing recurrence of change cycles within an organisation can in turn wear employees out. Tourism team members similarly report how change from a branding perspective is an ongoing process.

Being a market leading resort

Need to continually innovate

Evidence from this study reveals that change, as perceived by study participants, is necessary and thus is a continuous process. Max, a member of the tourism team describes the pressure his team experience as a result of the pressure to continually be a market leading resort:

“You know we’re quite an innovator and one of the market leading seaside resorts...but, that puts added pressure on us because we have to continually innovate because everyone else just copies things that we’ve done, which is good..you know we’re at the forefront, then we have to keep reinventing” (Max).

“Part of moving forward”

Reinvention was a recurrent theme within findings drawn from tourism participants, where it was largely deemed to be a necessary part of the business process. In that vein, Logan (Tourism) shares his view of change within the town and within the context of tourism development.

“Where the wealthier people have moved to, it changes. And I think it will change again, and people need to accept that fluidity because its part of...it’s reinventing yourself its part of moving forward.” (Logan)

Study findings indicate that there are varied perspectives of change. Members of the public health and tourism teams recognise both the challenges and opportunities that accompany organisational change within the context of the public health agenda moving to local government. Correspondingly, past research suggests that these individual differences may impact the commitment and success of organisational change (Walker et al. 2007; Judge et al. 1999). Research further suggests that these considerations are

important as certain types of individuals are more predisposed to positive reactions to organisational change efforts (Schneider 1987; McCrae and Costa 1986; Snyder 1974). Study findings and past research highlight the significance of considering micro-level factors like individual level differences within the process of organisational change in order to promote greater change success.

6.6 Identifying opportunities for positive outcomes from change

Change as a catalyst for creativity

“Reinvent and catch the trend of the day”

Findings drawn from interview data highlight a wide range of reactions to change. For example, there were participants who viewed change as being a positive mechanism to both inspire creativity and innovation within both individuals and the organisation. Participants from both tourism and public health stated how change could be viewed positively; Logan provides his thoughts on the issue of change from a tourism perspective:

“I think that there is a need to completely reinvent yourself periodically, a bit like pop stars. You take people like Madonna – she completely reinvents herself every decade and is still around...and, I think tourism and tourism wellbeing is something like that. If you use the same name all the way through it loses its impact it loses its appeal. Language changes, perceptions change and I think that you need to tune in to both of those things, language and perceptions to reinvent and catch the trend of the day. So ..I think that there is a need to rebrand and to keep things vital and refreshing.”(Logan)

“A chance to reset the slate”

This excerpt highlights the necessity for change from a tourism perspective as it is linked to a marketing or rebranding approach. Additionally, from a public health perspective a team member highlights how this repositioning of the public health agenda can be interpreted as an opportunity:

“Maybe following a big change, people psychologically maybe are a bit fresher..it’s been quite challenging, it’s been quite refreshing. It’s been a chance to reset the slate a bit and doing things a little bit differently, which is no bad thing...actually maybe that’s having a bit of a positive effect on people’s mood in the public services because now there’s a bit of a challenge to fight for, there’s something to do.” (Ethan)

In drilling down to a more granular level, within the public health context Isabella shares her perspective about the potential to identify opportunities for greater service efficiencies:

“Because some of these contracts weren’t held by us, they were held by the PCT. So it’s to understand some of the new stuff about that. It’s to identify opportunities to achieve improved effectiveness of the services that we commission, to improve efficiencies, a huge scope for that.” (Isabella)

Members from both public health and tourism teams recognise the potential connections between change, creativity, efficiency and innovation. These outcomes of organisational change can be further realised through interdepartmental engagement and collaboration opportunities within the local authority.

Being open to dialogue with other departments

Opportunities to work with the public health agenda

In the evidence gathered, both public health and tourism participants talked about the potential for dialogue, or synergies with other departments. From the tourism department Max shared his experience of working with public health team to date:

“I think they are fairly new on that, as we’ve only just taken public health within the council. I have only attended a couple of meetings so far, my presentations have all been about, this is where we are at, this is our stall, this is our strategy, there’s an opportunity to work with you guys around the health agenda, across the council...so come on let’s start that dialogue.” (Max)

In addition, from a public health team member, experience shared by participants indicates that the ‘dialogue’ between departments may be able to be mandated as groups like the health and wellbeing board and health scrutiny panel are now beginning to see how all of the work of the local authority is related to resident’s wellbeing. Lucy (Public Health) shares her view of the role of health and wellbeing within council:

“In fact at the health and scrutiny panel meeting..it was brought to the table that perhaps it would be a very good idea if every single project that the council embarks upon should consider the impact that it will have on the health and wellbeing of its residents – because its beginning to be seen that everything that we do has an impact on the wellbeing of residents”. (Lucy)

“Status quo is not an option”

In the identification of opportunities emerging from changes within the organisation of the local authority and the public health and tourism contexts respectively, there were frequent statements made about status quo no longer being an option. In many cases that would be how many employees would preface their vision for change within the patch they worked within. In looking at the potential for building a healthy tourism offer within the town, there was notable interest from participants in both public health and tourism communities, where both Ella, and Lewis each provide evidence for support:

“There seems to be a resurgence of attracting visitors to the town through the idea of [the town] being a healthy place.” (Ella)

“The third metric..so increasingly there is a market for mental, spiritual wellbeing...over and above the first two metrics of wealth and status. So that’s an area I am particularly interested in, trying to quantify that market, look at consumer behaviour and try to make a link between that and growing the product wellness breaks.” (Lewis)

From a public health perspective, building a healthy tourism offer holds some promise around some of the regeneration initiatives. Many participants suggest how regeneration efforts within certain areas of town, may tick boxes for both public health and tourism. Study findings indicate that participants from public health and tourism perceive the value of the destination being a healthier place for residents and tourists alike.

6.7 Conclusion

This chapter addressed the following questions: What engagement experiences contributed to synergies between wellbeing public health and tourism? What caused these engagement experiences?

Contrary to Lewin’s (1947) model of unfreezing-moving-refreezing model, study evidence suggests that participants experience an ongoing recurrence of change cycles felt within their respective teams. Participants from the tourism team commonly viewed change as a necessary part of the business process and part of the reinvention or rebranding process. Participants from both teams additionally viewed change as a means to promote greater levels of creativity, efficiency and communication. Evidence further suggests that change revealed how a great deal of work done within council has the potential to impact residents’ health and wellbeing. Study evidence revealed how the change in local government may present an opportunity to promote the town as a healthy place to live and to visit through the promotion of wellbeing activities. The process of change within this context presents a causal condition for the promotion of synergies between wellbeing, public health and tourism through engagement experiences focused on creativity, efficiency and communication, with the goal of promoting the area as a healthy place. In addition to the process of change, the concept of wellbeing is critically examined in Chapter 7 as an intervening condition to promote synergies between public health and tourism.

7. FINDINGS AND DISCUSSION: THE ROLE OF WELLBEING

7.1 Introduction

This chapter presents the findings and discussion related to the category, the **role of wellbeing** in promoting opportunities for synergy between local public health and tourism teams. As depicted in Figure 15 the chapter will explore the thematic category of the role of wellbeing within the five subthemes of: meanings and use of wellbeing, assumptions about wellbeing, connecting to societal wellbeing, barriers to achieving wellbeing; and levers to promoting wellbeing.

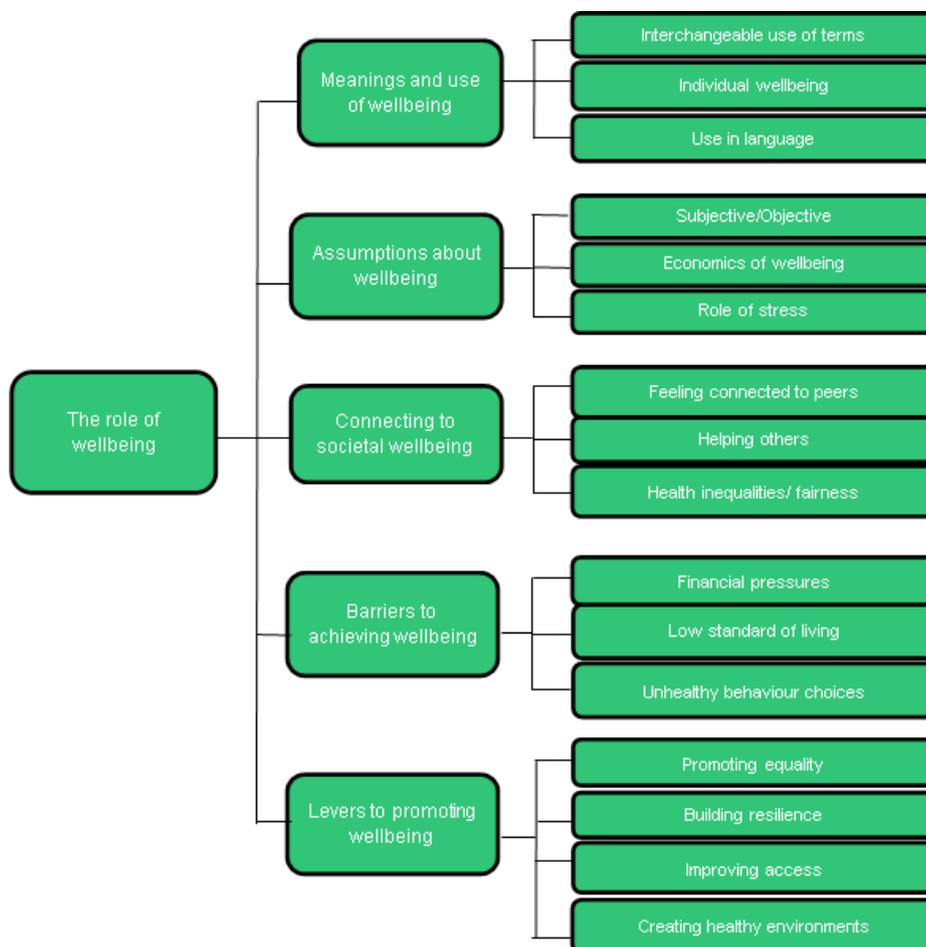


Figure 15: Framework for the role of wellbeing chapter

This chapter will be guided by the questions:

- What meanings do public health and tourism team members' ascribe to the construct of wellbeing? What are the benefits of these meanings?
- What engagement experiences contributed to synergies between wellbeing, public health and tourism?

7.2 Meanings and use of wellbeing

The evidence drawn from interviews with employees in public health and tourism departments working at local council, revealed the potential role of the concept of wellbeing in achieving synergies between these communities of practice. During this time of transition, with public health moving to the local authority, six months earlier (April 2013), both public health and tourism employees seemed to have differing perceptions around the meaning and use of the concept of wellbeing. This section presents the evidence and discussion as it relates to the perceived meanings of wellbeing as they relate to potential synergies between these two communities of practice.

Interchangeable use of terms

In the review of the evidence, one of the recurring themes identified by both public health and tourism participants, concerned the confusion around the meanings and definitions associated with the term wellbeing. The majority of the participants interviewed described how there were various definitions and understandings associated with the concept of wellbeing. During the interview process, many of the participants seemed to be brainstorming their ideas about wellbeing, where it seemed as though they were considering a range of meanings and interpretations whilst they were speaking. Evidence additionally revealed that the concept was used synonymously on many occasions with the terms wellness and happiness.

Wellness

The term wellness seemed to be mentioned predominantly in interviews with tourism participants. It was often mentioned in terms of how it differed from wellbeing where participants shared their views about the distinction between the two terms. Lewis, an employee with the tourism department describes his interpretation of the distinction between wellbeing and wellness and the interchangeable use within tourism practice.

“I think of wellness as more of an American term, I don’t know if that’s right..wellbeing I wouldn’t attribute to any particular culture or origin – it’s just a phrase. In the context of applying it to tourism, I’d say they are one and the same thing.” (Lewis)

Additional evidence gathered from an interview with an employee with the tourism community describes how he views the terms wellness or wellbeing to be interpreted amongst stakeholders within the hospitality sector. He further describes that while wellness and wellbeing are something that may be included within different tourism products or offers, there is a sense that it is not acceptable to use with tourism stakeholders outside of government. Jayden describes his feelings about the role of the

concepts wellbeing or wellness from his perspective of working within the tourism industry:

“Generally, the hospitality sector don’t use that terminology to describe what’s happening to their guests ...generally it’s not a term that actually figures, they don’t actually feel that they are playing a part in the sort of wellbeing or wellness...they are but, it’s not a term that they would routinely use.” (Jayden)

Current literature similarly recognises the confusion in research, with the terms wellness and wellbeing often being used synonymously (Huebner et al. 1999; Ryff and Keyes 1995). Despite the attention that has been given to wellness within extant literature, there is still a lack of agreement about its definition (Roscoe 2009). The evidence from this study would seem to echo the findings of past studies which underscore the frequent confusion around the meaning and the use of the term. Additionally, an important finding within this study was revealed in the evidence drawn from the tourism community, which highlighted the challenge in using the terms wellness or wellbeing with tourism stakeholders from outside local government. This perception could be explained by past research that indicates how the term wellness has been used predominantly within health domains (Kirsten et al. 2009; Myers 1992). This may also be partially explained by the lack of clarity around definition, and the fact that past literature highlights that wellness definitions seem to be predominantly rooted in health fields.

The review of literature reveals the wide use of the terms wellbeing and wellness in the health and tourism sectors yet, while these terms have been used synonymously, it is contended that there are distinct differences between them (Konu et al. 2010). It is suggested that the definition of wellness is linked to the coining of the term in the 1960’s when combining the words wellbeing and fitness (Dunn 1959). From this perspective, attaining a level of wellness is connected to the notion of balancing body, mind and spirit within the context of the social environment, culture and spirituality (Smith and Puczkó 2009; Hemmi 2005; Dunn 1959).

Current estimates place the value of wellness tourism at 563 billion (\$US) per year globally, with a 14% growth rate between 2013 and 2015 (Global Wellness Institute 2015). Wellbeing tourism is proposed to be contributing to the stress management, personal development, reflection, and connection and meaning outside of that derived from everyday realities (Kelly 2010) It is suggested that new forms of tourism are emerging beyond escapist forms of tourism, which typically involve more hedonistic behaviours and frequently include ‘switching off’ (Cohen 1996; Rojek 1993). These newer forms are more focused on health and rejuvenation and finding self-purpose (Kelly 2010). Thus, the evidence from this study highlights some of the challenges in using the terms wellness and wellbeing with tourism stakeholders outside of government, which

may threaten the ability of the area to access the projected value within the emerging wellbeing/wellness tourism market.

Happiness

Another term that was viewed to be interchangeable with wellbeing was that of happiness. Evidence revealed that participants both with public health and tourism departments drew parallels between the concepts of happiness and wellbeing. One of the views held from an employee with tourism is how through working on a strategy to sharpen the tourism experience or offer, that wellbeing and happiness could be seen as the same thing.

“I think happiness and wellbeing for me, are almost interchangeable terms you know, you are trying to get people to feel better than they do, before they have the experience really so..” (Jayden)

From this point of view it could be suggested that one of the motivations within the tourism team is to create an experience or offer that makes a person feel better than they do within their regular daily life. Conversely, from the health perspective, participants seemed to understand the concept of happiness/wellbeing more with their lives as a whole, not in relation to any sort of intervention or offer. That said, Daniel, an employee with the public health team, provides a differing perspective. The evidence presented here highlights how he views wellbeing to be underpinned by how happy people feel within their lives, further revealing some of the complexity involved in understanding the meanings and definitions surrounding happiness.

“I think there is something about whether people feel happy in their life – now you have to define happiness after that.” (Daniel)

The review of literature around happiness definitions seems to run parallel to the evidence gathered from this study. Happiness has often been defined as positive affect (Layard 2005), yet, it has also been used to refer to a predominantly positive mood (Diener 2006). Similarly, within psychology, happiness has been accepted as the sum of all pleasures and pains and the overall appreciation of one's life (Veenhoven 2003). As a construct, researchers have viewed happiness as being quite awkward (Seligman 2011), thus much time has been spent deconstructing happiness into more basic and measureable items (Foregeard et al. 2011). In the context of this study, this noted awkwardness provides a justification for the preferencing and use of the term wellbeing as opposed to happiness.

The evidence from this study would seem to suggest that tourism communities seem to align concepts around happiness and wellbeing to a more hedonic (subjective) conception of wellbeing and striving to attain greater levels of pleasure. Among the evidence gathered from public health, it echoed tenants of subjective wellbeing theory

which has been argued to be both hedonic and eudaimonic (Huta and Ryan 2010; Deci and Ryan 2008). This may present an area of synergy in practice, as current literature supports the notion that a life that is rich in both hedonic and eudaimonic pursuits is associated with a higher degree of wellbeing (Huta and Ryan 2010). Additionally, it is recommended that eudaimonia and hedonia ought to be considered mutually inclusive and should function in a synergistic fashion (Henderson and Knight 2012).

Confusion around meanings

Across much of the interview data there was confusion about the meanings and definitions of wellbeing, where there seemed to be a bit of difficulty encountered in attempting to clearly define the meaning of the concept. This is illustrated in a candid remark made by both Isabella and Ava, members of the public health team, who seemed to be hesitant to definitively state how wellbeing could be defined as a concept.

“Nebulous is probably a good description of it really...I don’t think that I really have come to grips with it as a concept” (Isabella)

“It’s difficult to put into words and to measure” (Ava)

The evidence highlights the challenge for both public health and tourism communities of practice to pinpoint the meaning(s) associated with the term wellbeing. Further, the interchangeability of the concept and confusion related to meanings may present a challenge to bridging communication across different areas of government as there seems to be much ambiguity around meanings and potential use.

Extant literature similarly recognises that interchangeable and misuse of the terms wellbeing, wellness, and happiness (McCabe et al. 2010; Conceicao and Bandura 2008). Camfield and Skevington (2008) recognise that this is due to the lack of agreement within the literature about how these concepts interrelate, brought on by the complexity and diversity in the range of definitions used (Andereck and Nyaupane 2012). Study evidence, drawn from both local public health and tourism employees, highlights both areas of challenge and potential around the interchangeable use of the terms wellbeing, wellness and happiness. Perhaps a forum for discussion in the local authority could provide greater clarity around meanings between different communities and look at suggestions for a more amenable term to both communities, to determine where there are parallels in understanding that may be harnessed in order to create opportunities for shared learning. Additionally, there may be an opportunity for practice to inform wellbeing research through the contribution of a conceptual definition which may help to synergise communities further optimising outcomes.

Individual wellbeing

An overall or total sense

In the varied interpretations of individual wellbeing there seemed a prominent focus on the notion of the total sense of being happy and of attaining a richness and diversity in life. Participants from public health more often associated the concept with an overall state of health. Ava, who works within the public health community shares her feelings about what individual wellbeing means to her:

“I think it’s not just about health but, people’s soul and how they are completely...It’s an overall sense of them being happy and well. It’s the total sense that they are having a good life really” (Ava)

In another vein, it was interesting to note that participants from the tourism community often spoke about the things that they enjoyed that perhaps did not fit within the classical sense of wellbeing, from their perspective. Participants, in a few cases, conveyed how work was an outlet that provided enjoyment, leading to a greater focus within that area. Logan describes how, in his view, work can be fulfilling if it is something that you enjoy doing:

“There are things you enjoy, there are things you don’t enjoy..and if you enjoy the work side, you’re in a job that is enjoyable..then that’s where you focus. It’s not wellbeing in the classical sense as you might see it” (Logan)

In the comparison of evidence that was gathered from public health and tourism communities, it was interesting to note that it was only the participants in the tourism department that associated enjoyment in life with work pursuits. Within the literature an interesting distinction is made between pleasure and enjoyment, where pleasure is described as the feeling that is derived from satisfying homeostatic needs like hunger and sex, and enjoyment refers to the feelings experienced when people break through from their limits of homeostasis (Seligman 2010). Moreover, it is contended that enjoyment is what ultimately leads to a level of personal growth and longer term happiness (Seligman and Csikszentmihalyi 2000).

The potential for wellbeing to be derived from work has also been highlighted within the literature where Schaufeli and colleagues (2002) define work engagement as that which includes: vigor, dedication and absorption. Further, absorption is likened to the state referred to as flow (Csikszentmihalyi 1990), or optimal experience, which can also be found within Seligman’s (2010) integrated wellbeing theory. Past research indicates that employees who had high scores in vigor, dedication and absorption were suggested to not be addicted to work, rather these individuals still enjoyed doing things outside of work and worked hard because they perceived work to be fun (Schaufeli et al. 2008).

Thus, this observation further raised questions about different conceptions of wellbeing and whether they may be aligned with different communities of practice and also how this evidence may help organisations to distinguish workaholism, associated with non-

wellbeing, with work engagement that is more often connected with wellbeing. In addition, work enjoyment is evidenced both within this study and the supporting literature to be an absorptive or flow state, linked to both enhanced personal growth and longer term happiness.

Longevity of impact

One of the significant elements to emerge from the evidence was from the tourism community, concerned what they perceived to be the relationship between the tourism offer for visitors and their overall levels of wellbeing. The evidence highlighted a potentially salient viewpoint within the tourism community around the impact of the tourism offer, where Jayden, employed within the tourism community shares his thoughts:

“I think wellbeing really for me, describes the average state you are in for your life over a period of time and I think a tourism offer for visitors coming in can really create a sense of wellbeing I don’t think it is as permanent as people would want from it. But..I don’t think it would quite be the same description as I would understand if somebody says, you know what was your sense of wellbeing about how you are doing, how you are living in an area, I think it would be a more even story or picture of it rather than the highlights” (Jayden)

Evidence from the tourism community highlighted the skepticism around how the local tourism offer may influence the wellbeing levels of the tourists or the local inhabitants. Wellbeing theory within the literature would both support and refute evidence from the local tourism community. The set-point theory of wellbeing (Lykken and Tellegen 1996) contends that long-term subjective wellbeing in individuals remains constant, due to personality traits and genetic factors (Headey et al. 2008). One of the contentious conclusions drawn from these findings is that subjective wellbeing is mainly pre-determined and that there is little that can be done by either the individual or public policy to enhance it (Sheldon and Lyubomirsky 2004; Lykken 2000;). More recent studies, however, argue that up to 40% of an individual’s wellbeing can be determined by intentional activity (Lucas 2007). Additionally, Diener and colleagues (2006) suggest that there are long-term fluctuations in subjective wellbeing and that adaptation to a set-point is often not predictable.

Evidence would then seem to support the set-point theory and thus, would challenge a real drive within that area of local government to actually create activities that would be aimed to improve overall individual wellbeing. In order to move forward to build a strategic alliance between local tourism and public health, perhaps it would be worthwhile to build an evidence-based case, highlighting the connections between healthy activity offers and long-term wellbeing. This may be an area of research worthy of further

investigation at the local destination level, to better influence the development of public policy in this area.

Being fulfilled/flourishing

Within the public health team the term flourishing and being fulfilled were used to describe what wellbeing may encompass. In both the public health and tourism communities it would seem that participants were trying to convey that wellbeing was associated with being fulfilled through doing the things that were enjoyable.

In the evidence drawn from public health employees, the opportunity to flourish was associated with finding ways to experience the diversity and richness in life and do things a bit differently. In reflecting upon his own life and career, Ethan a public health employee describes his thoughts that are associated with the concept of flourishing:

“I think it’s about flourishing isn’t it...It’s always quite easy to get stuck in particular grooves, and particular habits, and particular ruts, no matter what they are. They can be something as seemingly insignificant as doing the same things all the time in the same way and losing track of that diversity and richness of life around doing different things and finding the opportunities and doing things differently, I think it’s really important” (Ethan)

While there remains much debate within the literature, the majority of psychologists propose that both the hedonic and eudaimonic approaches underscore significant features of wellbeing (Henderson and Knight 2012). As a result, there are a growing number of integrated wellbeing conceptualisations (Huppert and So 2009) which combine features of hedonic and eudaimonic wellbeing, often referred to as ‘flourishing’ (Seligman 2010). Evidence from this study highlights the potential for a synergistic understanding in the interpretation and use of the word wellbeing as both communities of practice underscore the importance of flourishing in one’s life and to finding means in which to achieve this state of being.

Use in language

Recent use in the language

Evidence gathered suggests that while wellbeing as a concept may more recently be used within the language, it may just be describing something that historically, has been happening for a long time. Daniel, from the public health team describes how he perceives wellbeing to be only recently used within the context of the local authority and that it tends to be an acceptable term for use within council.

“Wellbeing seems to be much more acceptable use of language..so the local councillors seem to identify with wellbeing much more..wellbeing sort of got into the language maybe two or three years ago back ah, and is much more part of the language today than it was maybe four or five years ago” (Daniel)

Suspected trend

Conversely, the evidence gathered from tourism communities would indicate how the use of the word does not seem to be as accepted in the language, where there seems to be some skepticism. For instance, Logan takes issue with the use of the term as he shares his thoughts about how wellbeing merely describes something, within the context of the local area as a tourism destination that is not new but, is more historically embedded within the area.

“I think it’s a trendy title for something that’s been happening for a long time, in a lot of respects” (Logan)

Additionally, Lewis also employed within the tourism department, views wellbeing as something that from a marketing perspective could be capitalised on or exploited as a trendy niche:

“Wellbeing is something, if you were being cynical as a tourist destination you could capitalise on and exploit, a trend” (Lewis)

In addition, to tourism employees mainly viewing wellbeing as being in the language as part of a trend, Jayden also reveals how he perceives tourism stakeholders to be wary of the use of word, based on the fact that it is surrounded by a host of ambiguity, commenting:

“I don’t have a problem with the term, but, if I were to use it with the industry they might think that I was being a little bit, just trying to use jargon for the sake of it instead of really knowing what it meant” (Jayden)

A review of literature focused on the use of wellbeing within the language similarly recognises the challenges that are involved with aligning multiple discourses of wellbeing (Copestake 2008; Gasper 2007). Furthermore, Erault and Whiting (2008) propose that wellbeing discourse within the UK has been particularly unstable. Copestake (2008) however, suggests that talk about wellbeing can be useful in understanding the different ways that people think. Additionally putting forward the notion that wellbeing may be seen as a discursive space within which to understand parallels and why those involved in planning may either connect, or fail to connect, with each other. Alkire (2004) suggests that after recognising the diversity in wellbeing discourse, the next step is to reflect on how different sets of assumptions can best inform policy discussion and analysis.

The findings from this study highlight the differing levels of acceptance of the term wellbeing between the tourism and public health communities of practice, where there is a notable amount of scepticism about the use/validity of the term, particularly using the term with tourism stakeholders outside government. Further, this reveals a potential challenge in using the word wellbeing with tourism employees, as it would seem that there may be underlying assumptions which would potentially hinder communication

between these two communities within local government, as well as the broader community of stakeholders. Thus, this evidence would underscore the importance of building a better understanding of the breadth of wellbeing discourse with the aim of building more inclusive definitions and informing policy discussions.

7.3 Assumptions about wellbeing

Study findings highlighted the range of wellbeing dimensions underpinning participants' assumptions and viewpoints. Significant wellbeing dimensions that emerged from the data included: subjective and objective; economic; and the role of stress. The review of the data revealed similar underlying assumptions underpinning participants' perceptions about the dimensions of wellbeing.

Subjective/objective

Focus on the subjective

Study evidence revealed some confusion and debate around how wellbeing can simultaneously be both objective and subjective. One of the interviewees, in the process of brainstorming the complexity around wellbeing was led to ask:

"It's tremendously subjective, isn't it?" (Jacob)

Interview data revealed that many of the study participants recognised the complex nature of wellbeing only when they were asked to describe the meaning, at which point many would then discuss the highly subjective and contested nature of the concept.

The role of relativity

Subjectivity and relativity was something that was described mainly by employees within the public health team where there seemed to be an emphasis on how individual wellbeing would be affected by comparative wealth. Isabella, working with the public health team articulates her view of subjective wellbeing:

"It's about economic wellbeing but, again some of this is comparative, isn't it...relative you know, a poor man living amongst the rich is going to feel very poor and vice versa" (Isabella)

Extant literature within the area of objective wellbeing focuses more on empirically observable data concerning the conditions which affect the lives of individuals that is both measureable and analysable and often includes factors such as: life expectancy; income; nutrition; employment; education; or democratic participation (Wiseman and Brasher 2008). Subjective measures, however, tend to be based on psychological responses, which include personal happiness and life satisfaction (Haggerty et al. 2001). Similar to the evidence from this study, which indicated the perceived significance of both

objective and subjective wellbeing, many wellbeing scholars recognise the need for indicators considering both objective and subjective measures (Forgeard et al. 2011; Costanza et al. 2007).

Study evidence highlighted the overlap in the dimensions mentioned by both public health and tourism participants. This would further indicate a potential for both multiple wellbeing discourse in addition to the potential for harnessing meaningful views held and included within working definitions, action plans and policy direction. Additionally, the mention of the objective and subjective indicators of wellbeing may be an area for intra-organisational synergy in reconsidering the means in which citizen welfare is measured.

In the past, public health has been criticised as being reactive, using more downstream approaches. Local government may now be well positioned with the addition of 'Health Wellbeing Boards' and 'Public Health Forums', to envision a more holistic approach to health promotion. This direction may include the evaluation of subjective measures of wellbeing in order to assess population needs. Evidence seemed to indicate that more subjective measures of wellbeing were not currently being measured within local government surveys, with the exception of those being conducted within areas of severe deprivation. Perhaps this may be an opportunity for members of government to collectively determine what the area would look like when there are desired levels of wellbeing across the population.

Economics of wellbeing

The role of wealth

Findings drawn from the data revealed some of the different ways that participants perceived wellbeing to be connected to levels of wealth. Participants from the public health team mentioned the role of living in areas of deprivation and the connection to individual level wellbeing; this is illustrated in Daniel's statement about the correlation between happiness and wealth:

"People who are living in deprived circumstances or don't have a lot of money will often have a lower sense of happiness than people who are wealthy" (Daniel)

Within the literature there seems to be much debate about the role of wealth related to wellbeing where it could be argued that there must be enough to meet basic needs but, above that is there an actual increase in happiness? Lyubomirsky and colleagues (2005) put forward the notion that objective life circumstances have very little impact on individual happiness levels. More specifically research findings indicate that income levels have a minimal effect on happiness (Akin et al. 2009). Oishi and colleagues (2011) present study findings that suggest that money actually impairs a person's ability to savour positive experience and emotions. Furthermore, the economic literature focused

on the determinants of happiness, report stagnant happiness levels despite sizeable income increases (Inglehart 1996; Easterlin 1974).

Another participant from the public health team further remarked that she perceived that there was a growing disparity between rich and poor which was further reflected in levels of wellbeing. Isabella presents her feelings about the links between poverty and wellbeing:

“And my gut feeling is that the disparity in wellbeing is being extenuated, is growing but, that’s because I link wellbeing to poverty and relative economic wellbeing” (Isabella)

Further evidence that was gathered from this particular interview, also revealed how this disparity in health inequalities had an influence on personal levels of wellbeing. Extant literature also echoes similar research themes where, Alesina and colleagues (2004) propose that inequality may be perceived as a social evil. Similarly, study findings suggest a connection between happiness and inequality, as participants reported themselves to be less happy when there were high levels of inequality. Oishi and colleagues (2011), propose that this inverse relationship can be explained by perceived fairness and general trust. Moreover, it is put forward that in societies which are identified as socially immobile (UK), the poor have a deep dislike for inequality as they feel trapped (Alesina et al. 2001).

These study findings highlight how economic wellbeing, or a reference to financial levels can have several often conflicting connotations, further highlighting some of the challenges that may be encountered in communications between different communities within the local authority. Perhaps there are avenues for clarification around the specifics of how income levels and perceived inequalities are related to individual and societal levels of wellbeing.

Work/ life balance

Evidence revealed an acknowledgement that it was not enough to be merely financially successful, where participants suggested that there needed to be work/life balance in order to achieve a state of wellbeing. The relationship between work life and other areas of life was a theme that emerged from both public health and tourism interview data. Lewis, an employee with tourism describes wellbeing as a means to prevent work and success from dominating one’s life:

“There is genuinely that realisation that it is not just enough to be financially successful and you know to attain a particular status you have to balance that with a state of wellbeing otherwise..the other is finite isn’t it. But, one definitely has a correlation on your performance in the other” (Lewis)

Similarly, evidence drawn from the local public health team also highlighted perceptions of the connection between success in work and the transference to other areas of life. Ethan, a participant from the public health team highlighted this point:

“I think when you’re flourishing in your professional life, you flourish in other areas” (Ethan)

In support of study findings, there is a vast amount of research that supports the adaptive value of positive affect (Lyubomirsky et al). Also, theories drawn from positive psychology explain how ‘flourishing’ can extend into all aspects of life. Flourishing is proposed to be a means of living within the optimal range of human functioning and is denoted by goodness, generativity, growth, and resilience (Keyes 2002). Flourishing is suggested to contrast languishing which is connected with greater levels of distress, psychological impairment, restrictions to daily activities, and lost work days (Keyes 2002). Fredrickson and Losada (2005), contend that while positive affect is transient, the personal resources that are attained during moments of positivity are long-lasting. From this perspective, experiences of positive affect while ephemeral, can promote positive effects on growth and resilience.

Relating theory to implications for practice, inspiring positive affect through intra-organisational programming may not only impact current health and wellbeing, as espoused by traditional perspectives (Diener 2000; Kahneman 1999), but broaden and build theory further suggests that positive affect can also lead to future health and wellbeing (Fredrickson 2001). In addition, the mutual recognition of the links between personal wellbeing and work success may be an area for synergy between public health and tourism teams around issues of intra and inter-organisational wellbeing.

Financial level – the use of resources

In another vein, one of the councillors with the local authority described his interpretation of the role of finances in terms of service delivery. Joshua describes the connection between finances, resource use and quality of life:

“Well it’s not just at the personal level, it’s at the financial level, it’s about the use of resources to create that environment to deliver services....There’s lots of things in the quality of life arena that would be nice to have and whilst they are nice to have, somebody’s got to pay for them.” (Joshua)

Within the context of this particular interview it was also noted that it would be difficult to look at developing new priorities when, the current budget is able to just deliver on the priorities already identified. This evidence could be perceived as a more pragmatic viewpoint focusing on the budget allocation within the local government, further raising questions about the priorities necessary to achieve the greatest quality of life across the population level. Furthermore, quality of life could be an important starting point for

discussion, to assess how that could be evaluated, in order to best guide future budget decisions.

Extant literature both supports and challenges these study findings. In the context of the UK, the public health authority has spent over £1.8 billion in 2010 on health related problems resulting from lifestyle choices that include binge drinking, physical activity, and unhealthy eating patterns. That said, researchers have acknowledged the limitations of reductionist approaches to public health (Plesk and Grenhalgh 2001) where there is a shift in approaches emphasizing factors that promote wellbeing rather than merely preventing disease (Lindstrom and Ericson 2006). Thus, local government economic advisory teams may gain future inspiration from the review of past case studies employing social interventions which generate a high return on investment.

Role of stress

Evidence from tourism participants in particular revealed that, within this community, the removal of stress from a person's life is viewed to be an important element of wellbeing. Findings reveal the potential means of reducing stress within an individual's life and the potential role, that freedom from stress, plays in the planning and development of a tourism offer.

Putting things in perspective

Evidence, gleaned predominantly from interviews with the tourism team, revealed how wellbeing was equated with a life or environment that is essentially stress-free. Max, an employee with the tourism department highlights his view of what wellbeing is about:

"It's about dealing with life not being so crowded out with stress, with pressures and worries and things and putting these things in perspective" (Max)

From this perspective, Max views wellbeing as something that can be achieved through a stress free intervention, and he did go on to mention that going for a walk by the sea or doing things that you love, would be a means to de-stress. This study evidence is similar to past research which also acknowledges that stress can act as a powerful determinant of health (Marmot 2012; Wilkinson; and Wolf 2011). Marmot (2006) further suggests that chronic stress can make a person more vulnerable to a wide range of health problems.

Past literature focused on psychological wellbeing suggests that increases in mindfulness over time are connected with declining levels of stress and mood disturbance (Brown and Ryan 2003). Within this context, mindfulness has been defined as the maintenance of an aliveness of a person's consciousness to their present reality (Hahh 1976).

Having freedom

Logan also employed in tourism, likewise describes the role of stress within his conception of wellbeing but in addition underscores the role of freedom:

"I think the generally accepted concept of wellbeing is much more akin to being in an environment which is not a stressing environment and to having freedom in terms of time and choice, so there aren't pressures in terms of schedules"
(Logan)

Within Logan's interview, he shared the example of tourism products like organised tours which can have time pressures, which he described as more 'ticking the box' kind of tourism. These products he did not associate with achieving 'true' wellbeing. He further noted that the concept of wellbeing could be better achieved within an environment where the body and mind can recuperate.

Sheldon and Lyubomirsky (2007) within a eudaimonic intervention found that there was a higher likelihood of participants deriving greater levels of wellbeing from an intervention when they feel that it is freely chosen. Additionally, wellbeing theories identified with being more eudaimonic recognise the role of autonomy in achieving increased levels of wellbeing. Psychological wellbeing theory (Ryff and Singer 1998) and self-determination theory (Deci and Ryan 2000) suggest that the attainment of autonomy, amongst other criterion, may foster greater levels of wellbeing. In addition, it is contended that possessing a sense of agency or freedom seems to be connected to social, physical and mental health (Stansfeld et al. 2002). Henceforth, the evidence from this study around the notion of freedom would highlights tenets embedded within eudaimonic theories.

In the development of a new destination brand, the communication of the removal of stress and activities that promote mindfulness, could be co-developed and promoted through local public health and tourism. Evidence from this study, which was corroborated through extant literature, highlights the importance of considering a stress free offer in activity promotion. For example local planning collaborations may want to consider activities that promote mindfulness which could improve levels of wellbeing and the ability to cope with stress among both tourists and locals.

While there have been a wide range of dimensions to wellbeing explored, the majority of researchers contend that it is a multidimensional construct (Michaelson et al. 2009; Stiglitz et al 2009) which has also led to a somewhat befuddled research base (Pollard and Lee 2003). One of the noted challenges associated with the multifaceted nature of wellbeing is that there is a tendency among researchers to ignore this fact and focus on only one dimension, in turn ignoring many significant aspects of wellbeing (Foregeard et al. 2011). This notion could additionally be applied to planning within the context of the

local authority, where having a better local understanding of the multidimensionality of wellbeing may lead to enhanced policy decisions.

7.4 Connecting with societal wellbeing

Study evidence drawn from participants with both public health and tourism teams, highlighted the emergent themes of feeling connected, helping others and health equalities or fairness. Together these themes emphasise the significant role of social connections and the ways in which they may connect to health promotion.

Feeling connected to peers

Peer support

In reflecting upon the meaning of societal wellbeing, evidence highlighted the role of peer support in achieving this end. Jacob, a councillor with the local authority underscores this point in describing his perception of the role of networks as they relate to societal wellbeing.

“But, also how you feel supported by the people around you so there’s a network around you as well... wherever your peer support is...for me personally that’s what it’s all about” (Jacob)

Similarly, Isabella, a member of the public health team illustrates how close networks play a part in achieving societal wellbeing, when asked about what she believed societal wellbeing to be, she responded:

“It’s about social connectedness, close networks you have with friends and family” (Isabella)

From another perspective, the importance of social connection is illustrated through highlighting the side-effects associated with loneliness. Focusing specifically on the aging population, Daniel, a member of the public health team emphasises his view about the role of loneliness in elderly populations:

“there is a lot of work around loneliness in the elderly which suggests that you need to have the social side and we know from a lot of research that loneliness is linked to depression, is linked to poor quality of life and chronic conditions” (Daniel)

Lee and Robbins (1998) describe social connectedness as an aspect of an individual which reflects the subjective feelings of togetherness within an individual’s social environment. Additionally, social support and integration have been suggested to decrease the negative effects of stressful life events (Sasao and Chun 1994; Aldwin and Greenberger 1987). Similarly, literature focused on the impact of social connectedness underscores its role in the maintenance of health and wellbeing (Cohen et al. 2004). More generally, literature also connects social support with mental and physical health

through its influence on emotions, cognitions, and behaviours (Cohen 1988). Past research suggests that interventions developed to change a social environment and individuals' interactions have been successful in improving the quantity and quality of peoples' lives (Anderson 1992; Fawzy et al. 1990).

Loneliness has been connected to a range of negative health outcomes (O'Luanaigh and Lawlor 2008), where literature supports the health promoting effects of social relationships (Fratiglioni et al. 2004). More specifically, shortfalls in social support have been connected with many adverse health outcomes in the elderly (Reblin and Uchino 2008; Uchino 2006) which includes physical health and depression (Dennis et al. 2005). It is suggested that social isolation increases negative affect and feelings of alienation, further reducing feelings of control and self-esteem (Cohen et al. 2004). Past research illustrates that as social beings, humans are driven by the need to belong which is equally true of older adults (Depp and Jeste 2006; Baumeister and Leary 1995). Being rooted within a social network is also argued to promote behaviours that are health-enhancing (Kinney et al., 2005).

Thus, the evidence from these findings highlight the potential impact of social interventions on wellbeing which could be enhanced through intra-organisational collaborations. Additionally, UK seaside destinations tend to have higher elderly populations (Cave 2010), thus emphasizing the importance of local programmes that promote social engagement. Thus, work around social connectedness and the elderly may yield a high social return on investment (Lingane and Olsen 2004).

Sense of community

When participants were asked about their views of societal wellbeing, members from both the public health and tourism teams described the central role of community. Lewis, a member of the tourism team compared the UK to other places within the Mediterranean and how socialising took a very different form in warmer climates, he shares:

“They’ll just be out and be sociable and spend time with each other and that includes everybody from small children up to grandparents so that to me, now that is a real sense of community – here that doesn’t really happen” (Lewis)

Within the interview it was observed that Lewis looked to other models of community that he had experienced through travel and to the aspects that he wished to recreate within his current community. During the interview he did also suggest that he did not believe that building that type of community would be as viable within a more temperate climate, akin to that experienced in England.

From another perspective, Ella, who works with the tourism team shares her view about what she feels makes a community successful:

“I think that the most successful communities are those that work together and are given the opportunity to work together” (Ella)

This evidence seems to illustrate the importance of the provision of opportunities to work together and that being a necessary ingredient for community success. Similarly, Ava working with public health discusses why she feels that community cohesion is linked to people’s wellbeing:

“I think there is a strong link between community cohesion and people’s wellbeing because people feel connected in their community” (Ava)

The review of literature also supports these study findings where community cohesion is frequently connected with aspects of wellbeing (Cattell et al. 2008; Cutrona et al. 2000). More specifically, research has revealed the influences of social networks; social support; and processes of community empowerment on wellbeing (Layard 2005; Diener and Ratz 2000). Positive psychology views wellbeing as being linked to feeling good both about ourselves as well as about our social relationships within communities (Keyes 2002). The potential health benefits derived from social interaction and connection may serve as an area of parallel interest for tourism and public health communities of practice. Thus, there may be planning synergies around wellbeing discourse focused on the value of developing opportunities for social interaction.

Helping others

The evidence drawn particularly from the interviews with the public health participants, underscored how helping others was associated both with individual and societal wellbeing.

Doing things for others

Evidence which seemed to best highlight the role of doing things for others and the links to individual and collective wellbeing, Evie, a participant from the public health team, shares her perceptions about helping others:

“I think it’s a very basic premise that you feel better if you are helping someone else or taking part in community projects, it gives you a feeling of wellbeing.” (Evie)

Similarly, embedded within the roots of eudaimonia, Aristotle contends that helping others is a means to achieving higher levels of wellbeing. From this perspective, there is a claim that true happiness is found within the expression of virtue in turn, a happy person is one who is moral (Konow and Earley 2002). This perspective contrasts the hedonic approach which seeks pleasure and happiness for oneself to increase levels of subjective wellbeing (Meier and Stutzer 2008).

Additionally, volunteering is provided as an example that may positively affect individuals' wellbeing. An individual's wellbeing may increase because they enjoy helping others due to the intrinsic motivation to care about others' welfare (Menchik and Weisbrod 1987). Furthermore, it is suggested that volunteers benefit from intrinsic work enjoyment (Frey 1997; Deci 1975). The example of volunteering aligns with people's self-determination and feelings of competence, as it is proposed that intrinsic motivation involves people being at liberty to engage in activities they find interesting (Deci and Ryan 2000). Similarly, self-determination theory suggests that prosocial motivation can be built upon the desire to benefit others which supports feelings of identification and value congruence (Gagné and Deci 2005; Ryan and Connell 1989).

These findings may provide opportunities for building strategic alliances between public health and tourism within the area of volunteerism. In the act of helping others there is an opportunity for both locals and tourists, to engage in the action of helping others. Perhaps tourism events planning and public health programming teams may develop strategies which in turn could increase positive affect and levels of subjective wellbeing.

Providing facilities for communities

Evidence also revealed another means identified in helping others and that was through providing facilities in order to help community members engage in activities that may collectively improve their wellbeing.

“Whether providing facilities for communities to exercise and engage in ..activities that promote wellbeing whether there is evidence to show generally the socio-economic impact of that has been demonstrated.” (Lewis)

The evidence within this sub-theme seemed to highlight a distinct difference in approach to helping others between the public health and tourism participants. Public health participants interpreted the role of helping others to be focused more on giving back to a community with volunteerism being cited as an example. Therefore, with the aim of building synergistic alliances there may be a possible planning collaboration around the provision of access, where the tourism team provides support around infrastructure and the public health team offers knowledge about services and interventions.

Health inequalities/ fairness

Resources around vulnerable people

Evidence drawn from participants' responses about the nature of societal wellbeing prompted many responses around the theme of directing resources at the most vulnerable members of the community. Joshua, a councillor with the local authority shares his thoughts about the means to achieving greater levels of societal wellbeing:

“We’d be concentrating those sorts of resources around vulnerable people be they children or adults we’d be much more about trying to sort out those sorts of problems” (Joshua)

Similarly, Jacob, another councillor with the local authority discusses his view of how societal wellbeing may be achieved:

“For a society to be well you need every part of it to function at the appropriate level, which means that the most vulnerable, whether they are children, whether they are adults” (Jacob)

Innate fairness

From the public health team the importance of feeling equality within a society was emphasised to play a significant role in shaping societal wellbeing. Ethan, a participant from the public health team describes the role of innate fairness:

“I feel very strongly that the inequalities dimension is really important in the health of a society and the wellbeing of a society. So I think there is something about an innate fairness, that if people don’t see that fairness happening around them..i think it impacts negatively on the wellbeing of society” (Ethan)

Similarly, in the recent report of the National Equality Panel (2010), Britain was identified as an unequal country, more unequal than many of the other industrial countries and more so than it was for previous generations. Furthermore, the report highlights how the gap between those who are well off and those who are less off tends to manifest in a range of ways. There is a growing acceptance of the notion that the welfare of individuals depends quite heavily upon their relative position within a society (Hopkins 2008). In another vein, a path analysis conducted by Kawachi and colleagues (1997) indicated that income inequality was actually a reflection of low social capital, where the latter leads to mortality.

Evidence from this study would indicate that there is a concern about vulnerable populations and greater equality within society, amongst councillors and public health team members. Therefore, there would seem to be greater onus on addressing societal health inequalities and means across departments to redress the balance. The evidence would suggest an opportunity for intra-organisational collaboration to better harness resources, to build local strategies to promote fairness and greater equality in areas of deprivation or most need.

7.5 Barriers to achieving wellbeing

The analysis of study findings revealed the main themes identified to challenge current levels of individual and societal wellbeing. Salient themes identified within this study addressing barriers to wellbeing include: the economics of wellbeing, low standards of living, and unhealthy behaviours.

Economic climate

Financial pressures

The evidence drawn from both public health and tourism participants highlight a perceived link between the current economic situation and a decline in wellbeing. When prompted to respond to his thoughts about the current levels of wellbeing observed in society, a participant working with the tourism department shared his view of the impact of experiencing financial pressures:

“Economically I think we are all going through a tough time at the moment, everyone’s under a bit of pressure financially” (Max)

In a similar vein, a participant from the public health team shared her observations of the impact of economic worries on population level wellbeing; Mia describes how she perceives levels of wellbeing within the last few years:

“I think our wellbeing is...not as good as it was a few years ago because people are walking around with great weights on their shoulders around employment and everything related to economic worries” (Mia)

This evidence is supported by Bell and Blanchflower (2010) who suggest that the UK economy went into recession during 2008 which was signified by declining outputs and increasing unemployment rates. Further they proposed that this 2008 recession was the greatest shock to UK output since the Great Depression, thus being termed the ‘Great Recession’. The economic challenges experienced within the UK have also been correlated with decreases in health and wellbeing where there is much research attention focused on the health effects of the ongoing economic crisis (Stuckler et al. 2010). Mounting research studies additionally highlight a correlation between the recession and higher suicide rates (Economou et al. 2011; Stucklet et al. 2011).

Lowered aspirations

An additional challenge of unemployment is the impact on an individual’s level of self-esteem and wellbeing. Ava, a member of the public health team describes the challenges of being on long-term benefits and how it may affect aspirational levels:

“So a lot related to money and the fact they have been on benefits for a long time and they don’t seek work and their self-esteem is very low, so that’s a barrier to wellbeing..I think maybe their aspirations are very low” (Ava)

Literature highlights the contention that individuals with low self-esteem are more predisposed to externalising problems such as delinquency and antisocial behaviour (Fergusson and Horwood 2002; Sprott & Doob 2000). Donnellan and colleagues (2005) further propose that the link between low self-esteem and externalising problems is underpinned by traditions within social sciences. Accordingly, social bonding theory

suggests that weaker ties to society lower adherence to social norms and further increase delinquency (Hirschi 1969). Study evidence is thus supported by extant literature and highlights the importance of addressing challenges facing individuals with financial difficulties and the need for regenerative programmes and services that may be offered through intra-organisational synergies within the local authority.

The stress of 'stuff'

Participants with public health and tourism both identified the connection between consumption and levels of happiness. Logan, working with the tourism department shares his perceptions of the connection between consumerist drive and increased levels of stress:

"I think that once you get on that conveyor belt of mass consumption, life becomes incredibly stressful without people knowing it.. consumerism becomes the end all be all of life. And you see people striving, and what are they striving for, they're striving to have a better car, the better house..and that goes quite against the definition of wellbeing because stress levels do increase as you earn more and own more" (Logan)

Additional evidence derived from an interview with Evie, a public health employee conveys how she feels about the growth paradigm and mass consumption:

"So that whole cloak that's been built around, stuff makes you happy and all that marketing smel and if you have this you will be happy and if you have that you will be happy and I don't know how we are ever going to turn that around" (Evie)

Postmodern theories of consumption propose that consumers no longer consume products based upon their mere utility rather, they are consuming the symbolic meaning of the products as represented within their images (Baudrillard 1981). It is further suggested that the consumer then becomes a consumer of illusions (Debord 1977) as well the 'ad-dict' is merely buying images and not things (Taylor and Saarinen 1994).

Also, Lane (1999) suggests that money used for the purchase of goods, does not contribute to greater levels of happiness. In addition, it is argued that the growth economy will always lead to unhappiness, frustration and dissatisfaction due to the connection between goods production and wants production (Carlisle and Hanlon 2011). In turn, while economic growth has in past decades delivered health and social benefits to citizens, increasing research evidence shows that such growth in fact threatens human wellbeing (Carlisle and Hanlon 2011). This acknowledged divide between the abundance of goods and services and citizens' subjective wellbeing is often referred to as the Easterlin paradox (Di Tella and MacCulloch 2005; Easterbrook 2003).

Low standards of living

Participants when prompted to share their views about the greatest challenges to wellbeing, frequently described the consequences of living within areas of deprivation and subsequent area effects.

Areas of deprivation

Within this context, the term deprivation refers to a standard of living which is below that of the majority of society, involving underprivileged and inadequate access to resources (Herbert 1975). The concept of deprivation includes a wide range of issues and refers to unmet needs as a result of a lack of resources, not just financial. Deprivation in an ongoing measure of relative deprivation therefore, there is not an exact point on a scale which considers an area to be deprived (Communities and Local Government 2011).

Highlighting the negative health and wellbeing outcomes of living within areas of deprivation, one of the councillors with the local authority highlighted the difference between life expectancies through living within different areas.

“In [area of deprivation] I think the life expectancy is a good ten years below..to where I live. So seriously, we have got drug and alcohol problems, anti-social behaviour, we’ve got people living on the streets” (Lawrence)

These challenges are also noted by an additional councillor who underscored the associative issues connected with areas of deprivation, Lucy shares:

“In [area or deprivation] one of our problems is that we have a high density of people with multiple health issues, that’s addiction issues, a fairly low standard of living and a low educational level, low incidence of being in work and all of those things really contribute to having a low level of wellbeing” (Lucy)

Research increasingly suggests that there are linkages between residential location and life chances (Atkinson and Kitrea 2004; Bourdieu 1999). The notion of ‘area effects’ proposes that a person’s prognoses for social engagement and economic activity are associated with the neighbourhood in which they live (Atkinson and Kitrea 2004). Literature focused on area effects suggests that experiences of deprivation may be further entrenched and fatalistic within deprived areas due to the perceived negative impacts of the area on both social action and engagement (Atkinson and Kitrea 2004). Furthermore, it is acknowledged that adverse area-induced effects infer that social exclusion within these deprived areas is increasingly difficult to tackle (Dabinett et al. 2001; Power 2000).

Housing

Housing was additionally highlighted as an area of concern as participants often connected poor housing with behavioural challenges further threatening levels of wellbeing. Ava, a member of the public health team shares her thoughts about the connection between housing and levels of wellbeing:

“So if you move into one of those flats, your wellbeing, then your health is more likely to decline, or have unsocial neighbours, there’s lots of drug and alcohol and prostitution around you” (Ava)

This evidence underscores the challenges associated with areas of deprivation and also the potential role of social isolation or exclusion within these areas.

Worklessness (intergenerational)

Study evidence revealed the connection between worklessness and levels of wellbeing. Where further challenges were highlighted around the issue of entrenchment. Lucy, a councillor with the local authority highlighted the challenge of intergenerational worklessness for youth to overcome:

“There is a huge preponderance of council housing and intergenerational worklessness and a great difficulty for young people, to aspire past that, so it’s a little bit entrenched” (Lucy)

Daniel, a participant with the public health team, shares his thoughts about worklessness and its connection to lower levels of wellbeing:

“I think people who have been economically inactive for a year, I think we’d find lower levels of wellbeing” (Daniel)

Literature similarly proposes that worklessness can be, in part, explained through the inheritance of beliefs and practices which discourage employment and encourage dependency on welfare is powerful (Shildrick et al. 2012). Furthermore, it is put forward that there is increasing interest in the desire to tackle intergenerational diffusion of welfare dependency (DWP 2010) and cultures of worklessness (DWP 2012). Literature also highlights concerns about youth and their difficulties accessing the labour market with over one million 16 to 24 year olds currently not in education, employment or training (ONS 2012).

Recent findings also suggest that there are a number of issues that are related to social exclusion and poverty which combine to distance people from the labour market and include: problematic drug and alcohol use; poor schooling and educational underachievement; offending and imprisonment; domestic violence and family housing instability; and physical and mental ill health (Shildrick et al. 2012).

The impacts of area effects on wellbeing may have implications for intra-organisational synergies. Within the local authority, evidence from the public health team has underscored the drive to have health and wellbeing embedded across the organisation, that the wellbeing of the local population be considered in every decision made across the organisation. Specifically, the public health and tourism teams may find synergy in the regeneration of areas of deprivation – further improving local wellbeing and diversifying local tourism destination offerings.

Unhealthy behaviour choices

Alcohol and exercise

In the review of the evidence drawn from public health interview data there was some mention of the impacts of alcoholism and over-eating had on wellbeing. Daniel (Public Health), shares areas challenging levels of wellbeing:

“So every local area talks about what it feels its priorities should be and then you hone into what your wellbeing is..so quite a lot of universal ones come out like, not enough people take enough exercise, there’s too many people that drink alcohol” (Daniel)

This evidence infers that lack of exercise and excessive alcohol use are identified as universal priorities within public health. Past research conducted suggests that low physical activity is the most dominant disease risk factor in England, where approximately 95% of adults do not meet the minimum physical activity guidelines (Troiano 2008). It is further contended that while the challenge of physical inactivity to public health finances is recognised, the fact that it is also the primary cause of most chronic diseases is often ignored within health strategies (Weiler and Stamatakis 2010). In the UK, it is put forward that chronic diseases share risk factors including alcohol use and a lack of physical activity (WHO 2002). Based on county-wide studies it is estimated that by 2020 one in ten local people could have diabetes and one and eight could have heart disease (STP 2016). Over £9 billion direct and indirect health-care costs can be attributed to physical inactivity, with an additional £2.5 billion of inactivity contributing to the obesity problem (BHF National Centre for Physical Activity and Health 2013).

Obesity

Another member of the public health team brought up the additional concern of obesity. In the context of evidence drawn from an interview with Mia, when she was asked to share what her perceptions were of the levels of wellbeing currently within the town she visually was seemingly unhappy with what she saw:

“On a physical basis, I am looking around at wellbeing and thinking that there are far more obese people around then there used to be.” (Mia)

Findings report that obesity increases the risk of type 2 diabetes, cardiovascular disease, and many forms of cancer (Wang et al. 2011). It is further estimated that each year cardiovascular diseases are responsible for greater than 200 000 deaths within the UK, and cancers represent an additional 156 000 deaths and it is accepted that the issue of obesity represents part of the cause of these diseases (Allender and Rayner 2007; Allender et al. 2006). In a 2007 report published by the UK’s Office for Science Foresight Programme predicted that the continued increase in obesity will equate to £5.5 billion in medical cost to public health by 2050.

In the UK the costs associated with physical inactivity are estimated at £8.2 billion (Troiano et al. 2008), alcohol £3.0 billion (Balakrishnan et al. 2009), and obesity at £4.2 billion (Health Survey for England 2008). Study evidence are supported by current research, which highlights the challenges faced by the local authority of building a health and wellbeing organisation through health promotion, when there is a large percentage of budget currently allocated to treating disease. Perhaps this challenge underscores the importance of optimising human and fiscal resources, in the promotion of healthy lifestyles and services across departments in the local authority.

The challenges around alcohol consumption and levels of exercise are issues to destination management when there is a thriving night-time economy. Perhaps the evidence from this study may provide an alternative destination marketing strategy to include wellbeing activities and events i.e., adventure sport races and heritage festivals.

7.6 Levers to promoting wellbeing

Promoting equality

Evidence from this study highlights the theme of inequalities and the potential means of addressing imbalances. Societal equality, whilst a significant theme emerging from the study, was drawn mainly from data collected from participants within the public health team. Interview data revealed the importance of: determining the underlying social structures, diversifying approaches to wellbeing, community members feeling unequal, and resources targeting the most vulnerable.

Findings drawn from the interview data with Evie, a participant from the public health team, reveals how she perceives a relationship between equality and a happy and well society, remarking:

“I think a more equal society can lead to a happier society and a more well society” (Evie)

Past literature also supports this study finding where Wilkinson & Pickett (2006) report that more equal societies are more likely to be healthier. A review of extant literature reveals that health and equality tend to more often be correlated (Winkelman 2012), however, there is less support for the links between equality and happiness. Within current research, there have been very few attempts to define inequality as it relates to happiness or subjective wellbeing (Ferrer-i-Carbonell and Van Praag 2003). That said, Alesina and colleagues (2002) propose that individuals are less likely to report themselves as happy where there are high levels of inequality in society. In the findings from this study, interview data seemed to indicate that there was a genuine perception that a more equal society could be equated with higher levels of wellbeing within society.

Similarly, it is put forward that wellbeing levels within unequal societies have been stagnating (Winkelman and Winkelmann 2010).

Additional research provides strong support for promoting greater levels of equality within society where it is also suggested that the quality of social relations within a society is reduced when there is greater inequality (Wilkinson 2005). Also, there is mounting research which suggests that there is a strong correlation between higher inequality and higher homicide rates (Wilkinson & Pickett 2007). More specifically, it is proposed that in Britain, health inequalities make reference to the difference between social groups (Black et al. 1988). Additionally, Marmot and Bell (2012) contend that higher levels of disadvantage are associated with worse health outcomes, where there is a marked correlation between negative health outcomes and levels of neighbourhood income deprivation.

The underlying social structures

When Mia was asked about her thoughts about how wellbeing may be improved within a society, the response seemed to be aligned with more of an upstream approach to wellbeing. Within this interview, the participant seemed to have strong feelings about the challenges that she observed within society from her lens as a public health professional, she explains:

“In an ideal world, I would deal with the underlying social structures and social issues of society, the economy, the cost of housing. It is those underlying issues, education ...that would address better wellbeing as far as I am concerned.” (Mia)

The review of the seminal works of Marmot (2001) and Wilkinson (1997) similarly highlight how underlying social structures will impact individual and societal levels of wellbeing. In that vein, research contends that health inequalities are connected to the underlying issues of poverty, health and inequality (Marmot 2001). Wilkinson (1997) observes that during the 1980s income differences widened in Britain more so than in other countries; where nearly a quarter of the population live in relative deprivation.

Employing different approaches

From another perspective, Isabella emphasised the importance of understanding some of the complexity involved in tackling health inequalities, stressing the importance of moving away from the more universal approaches in public health:

“So if we are going to develop services and look to address some of the health inequalities in those two areas, you may do it in two totally different ways because of the nature of those communities.” (Isabella)

Past research has similarly highlighted the complexity of public health issues and a need to better understand individual and population level experience (Hanlon et al. 2011). To

this end, research supports the call to approach public health differently than it has in the past, paying closer attention to the social determinants of health.

Targeting the most vulnerable

From the perspective of achieving the best results with local budgetary resources, Isabella shares her thoughts about how to achieve the best value. Isabella, a participant with the public health team suggests:

“How do you achieve the best value for your spend, how do you get the best results from what you are doing? You target the people who need it the most.”
(Isabella)

In a similar vein, Marmot (2012) refers to this approach as proportionate universalism. Proportionate universalism is an approach where actions are universal yet, the intensity and scale are proportionate to levels of disadvantage (Benach et al. 2013; Marmot 2010). Thus literature echoes findings from the study where both councillors and public health participants often suggest that the best way to get value on your spend is to focus efforts on the individuals and communities that have the greatest need.

Findings from this study suggest that wellbeing may be improved through: the promotion of greater levels of equality; targeting the underlying social structures, employing proportionate universalism as an approach and; diversifying approaches to health issues. Thomsen and colleagues (2010) suggest that vulnerable people, in light of a range of social and structural factors, will be in need of a greater amount of healthcare than those that are rich. Interventions that aim to target health inequalities through the provision of opportunities for all members of society to enjoy good health, include social factors of: education, employment, housing, living conditions and social wages (Thomsen et al. 2010).

Specific to this study, the challenge of inequality and health inequalities is a challenge that arguably does not rest merely with one department within the local authority. Rather, applying the approach of universal proportionalism could be employed by both public health and tourism teams. For example, improving the living and social conditions within an area could also serve to diversify the tourism offer and the destination branding strategy more generally.

Building resilience

In working towards making a difference within their areas, participants with public health highlighted the importance of: what will make the biggest difference, namely, building resilient communities and inspiring new horizons.

What will make the biggest difference?

Within the public health team, participants revealed a genuine interest in wanting to understand the root causes of low wellbeing to further address the significant issues. The evidence from interview data with Ava and Isabella underscore the importance of first finding the trigger causing challenges to wellbeing:

“What is the trigger? One thing leads to another leads to another. Which thing do we need to improve first and what thing will make the biggest difference?” (Ava)

“If we can understand what’s driving the low wellbeing of those people experiencing the least levels of wellbeing and really try to address those issues....” (Isabella)

Seminal work focused on health inequalities echo these findings, where Wilkinson and colleagues (2011) suggest that inequality (income distribution) may be central to embedded social problems that are connected to relative deprivation, low social status and poverty. In addition, world leaders and international organisations have identified income inequality as one of the most significant current issues, many also emphasizing the related social costs (Elliot 2014; Obama 2014; World Economic Forum 2014; Lagarde 2013; Cameron 2009). In addition, it is contended these inequalities are not always a result of genetics, lifestyle factors and behavioural choices, thus why they are deemed to be inequitable (Wilkinson et al. 2011). Increasingly current research suggests that a wide range of social outcomes connected with deprivation within societies are more prevalent in those with larger income disparities (Pickett and Wilson 2015).

Building resilient communities

One of the themes emerging from evidence from the public health team was around the notion of building resilience in individuals and communities. Drawn from an interview with Ethan with the public health team, he emphasises what, as a community, we need to talk about more:

“So we don’t talk enough about happiness and what are the conditions that are likely to promote happiness and most importantly lead to resilience in individuals and communities to be able to cope with adversity but, emerge stronger, wiser.” (Ethan)

Within the interview with Ethan he cited examples of interventions for children that are in difficult living conditions, living in areas of deprivation, where one of the examples provided was the importance of developing empathy in early years particularly nought to five. Literature also echoes the significance of this type of intervention where seminal work by Marmot (2010) suggests that one of the best means of achieving greater wellbeing within society is by offering children the best chances for success in life. Findings from this study also support the need to utilise integrated wellbeing conceptions in planning, those which combine features of both hedonic and eudaimonic wellbeing (Seligman 2010).

Providing new horizons/seeing opportunities

A perspective shared by one of the public health team was the importance of making a difference through showing individuals a view of something that they may be able to aspire to, Lucy shares her views:

“There we are trying to give new horizons and to increase the wellbeing of those people because there’s quite a large amount of depression in that entrenchment..you need to be able to show people that there is something else as sometimes they can’t see it” (Lucy)

Similarly, Sen (1992) likens poverty to ‘capability deprivation’ where poverty removes our ability to exercise agency. That said, Sen further suggests that to be successful, anti-poverty interventions do need to offer freedom to involved individuals and communities. This parallels wellbeing integration theories which also highlight the importance a ‘sense of control’ as with Csikszentmihalyi’s flow theory or ‘meaning and purpose’ identified in Seligman’s wellbeing theory. Thus, the integration of hedonic and eudaimonic pursuits may be a way to build strategies between tourism and health departments within the local authority and increase levels of wellbeing for locals and tourists.

In looking towards future synergistic strategies, Marmot and Bell (2012) suggest that policies need to both address people at the bottom of the health gradient as well as the gradient as a whole and ensure that policy impacts are proportionately greater at the bottom end. This approach, they refer to as proportionate universalism and refer to the need for action across all of society which focuses on the social factors which influence health outcomes (Marmot and Bell 2012).

Improving access

Within both data drawn from public health participants and those from the tourism team, the theme of access was suggested as a means of improving levels of wellbeing within the community.

Service provision

When participants were prompted to consider means of improving the levels of wellbeing within their remit, one of the councillors described his approach to service provision:

“The democratic process is about the provision of services and if you can manage to achieve an improvement ongoing then presumably people will be happier, provided it doesn’t cost them more. So our strategy is for it not to cost anymore and to continually improve services” (Joshua)

In the interview with Joshua, he stressed the importance of the effective use of resources in the delivery of council services. Within this segment of evidence, he makes a

connection between happiness or wellbeing of the local population and continual service improvement. Connected to levels of service improvement is the concept of access.

Facility and service accessibility

Participants from public health and tourism departments highlighted the connection between service and facility accessibility and wellbeing. Isabella, a participant from the public health team shared her vision about how a healthy, accessible offer may be beneficial to both visitors and locals:

“We may have all these things that appeal particularly to visitors, healthy activities, sporty activities. The issue for us if we are looking at addressing health inequalities in our resident population is in how to make these services more accessible to those groups” (Isabella)

Additionally, Jayden a participant from tourism shared his view of how facilities will ultimately help to tackle some of the main challenges to wellbeing:

“So the facilities that are there to make people feel better are things that in the long run will help with obesity hopefully...from a destination point of view, there are people in our community here who are probably not feeling able to use the facilities because we haven’t thought about what they might need and it might not be very much but, we might need to put it in place for them” (Jayden)

Access to the seafront

Access to the seafront was identified by both public health and tourism participants as an important factor to individual wellbeing. Max, a participant with the tourism team highlights how better access to the seafront may be achieved:

“Well I suppose it’s about access. Access to information, access to services..and a lot of these are driven by trying to enhance the ability for people from all walks of life and all mobilities and ages to really access the seafront and make use of it. Improving lighting, improving access to things like lifts and some of the zigzags down to the beach so it becomes easier for people to get down here and use the seafront” (Max)

Past research emphasises the significance of access to natural areas and recreation activities and facilities. Insufficient access has been connected to: a lower quality of life (LaVeist 2004), low levels of physical activity (Humpel et al. 2002; Ball et al. 2001) and obesity (Norman et al. 2006). Hence, a strategy to address better access to the seafront, natural and recreation areas may be an area for synergy between council departments.

Social connectedness

Activities promoting interaction

Participants from both public health and tourism departments noted the important role of social interaction as it relates to an individual feeling better. Ella, a member of the tourism team describes her view of societal wellbeing:

“Interacting with people...experiencing parts of the culture..it can be a whole portfolio of ways to make your life feel better... exercise for example, cuts across the social interaction of people coming together to achieve something” (Ella)

In a similar vein, Bourdieu (2000) supports the process of addressing the issues of social exclusion through leisure as related to the local agenda. It is further contended that the real value of leisure whether it be sport, arts, or socialising is in its ability to bring different people together (Blackshaw and Long 2005). Additionally, various scholars suggest that different forms of leisure can contribute to developing social capital (Jarvie 2003; Hemingway 1999). Another important consideration of local level planning is around the concept of community cohesions and the potential connections to the promotion of wellbeing.

Community cohesion

Ava, a member of the public health team highlights the importance of people feeling connected to their community:

“Then I think there is a strong link between community cohesion and people’s wellbeing because people need to feel connected in their community” (Ava)

Extant literature proposes that across the lifespan, individuals who are embedded within a social network or personal relationships have a greater level of wellbeing than those individuals who are socially isolated (Machielse 2006; Fioto 2002). Colin-Thomé and Fisher (2013) contend that a community-development approach can bolster confidence in turn catalysing action towards health improvements. Where it is further proposed that the community development approach can extend and reinforce social networks (Colin-Thomé and Fisher 2013). Extant literature highlights the current gap in evidence connecting community empowerment and health improvements (Colin-Thomé and Fisher 2013). Evidence suggests that community empowerment is cost-effective, not only in deprived areas but, all economic climates (Knack 1999). It is proposed that making resources available which address the links between poor social networks and poor health in turn breaking the cycle of deprivation has been associated with reduced healthcare costs (The Marmot Review 2010).

Four local authorities have used a social value approach in order to measure the economic return on investment on community development. For example, within the

Beacon estate in Cornwall where the approach was adopted within rural and urban estates, led to improvements in education, employment and crime (Morgan and Swann 2004). In turn, the approach can help health and wellbeing boards evaluate the social capital within their communities and further track any changes resulting from an intervention. Findings from the study further proposed that an investment of £233 500 in community-development finds a return of £3.5 million in social return which represents a return of 15:1 (Thome and Fisher 2013). In addition, Lomas suggests that facilitating social networks has a comparable impact to that of medical interventions. Lomas further contends that for every 1000 people exposed to an intervention each year: social cohesion could prevent 2.9 fatal heart attacks and medical care and cholesterol lowering drugs would prevent 4.0 fatal heart attacks in screened males.

Study evidence identified some of the levers to achieving wellbeing which include: promoting equality, building resilience, improving access and social connectedness. Study findings suggest that equality can be promoted through addressing the social structures contributing to health inequalities using the approach of proportionate universalism. To build resilience in communities, findings suggest that similar to 'sense of control' within flow theory (Csikszentmihalyi) that people living with 'capability deprivation' (Sen 1992) need to be provided with new horizons to increase their levels of wellbeing. Improving access to natural areas and wellbeing activities was recognised by both public health and tourism team members as a means to improve individual level wellbeing. Study findings additionally recognised the links between social connection and community cohesion and wellbeing where the promotion of interaction in wellbeing activity offering may present an opportunity for public health and tourism teams to work together.

7.7 Conclusion

This chapter critically examined the role of wellbeing in synergising local public health and tourism teams under the sub-headings of: meanings and use of wellbeing, assumptions about wellbeing, connecting to societal wellbeing, barriers to achieving wellbeing, and levers to promoting wellbeing. Study evidence examined, addressed the following questions: What meanings do public health and tourism team members ascribe to the construct of wellbeing? Are there benefits associated with these ascribed meanings? What engagement experiences contributed to synergies between wellbeing, public health and tourism?

The analysis of interview data highlighted how difficult the concept of wellbeing is to define, often being used interchangeably with wellness and happiness. Study evidence revealed that the point of intersection to participants' understanding of wellbeing could

be best understood in integrated conceptualisations of wellbeing theory, combining features of hedonic and eudaimonic wellbeing. This is often referred to as 'flourishing' (Seligman 2010), research further suggesting that the pursuit of both hedonic and eudaimonic pursuits will achieve the highest level of wellbeing (Huta and Ryan 2010). In turn, this offers an area for potential planning synergy in the design of wellbeing activities which include eudaimonic and hedonic elements for both residents and tourists. Study findings also reveal the different levels of acceptance in using the term wellbeing between local public health and tourism teams, where tourism participants illustrated their scepticism with its use, particularly with stakeholders outside of government. These findings highlight the importance of building an inclusive wellbeing conceptual framework to inform local policy decisions.

Evidence from the study also highlighted goals of social interaction and community cohesion, where there is the potential of social interventions on wellbeing to be enhanced through intra-organisational collaborations. The challenge to wellbeing in the UK also highlighted areas that could be addressed through the collocation of wellbeing strategies addressing alcohol consumption and physical activity levels and offering destination rebranding opportunities. One of the prominent themes emerging from the public health and tourism data concerned the issue of improved access to natural areas and wellbeing activities which may both improve individual level wellbeing and reduce health inequalities. The context of place in promoting greater levels of wellbeing through intra-organisational synergies will be addressed in the next chapter, Chapter 8.

8. FINDINGS AND DISCUSSION: THE CONTEXT OF PLACE

8.1 Introduction

This chapter presents study evidence, relevant literature and discussion associated to the role of the context of place in the creation of a strategic alliance between public health and tourism communities within the local authority. Evidence is drawn from the analysis of interview transcriptions with public health and tourism staff and elected members of council within a local council in the south of England. As shown in Figure 14, the chapter will examine the context of place within the five sub-categories of:



Figure 15: Framework for the context of place chapter

understanding place through health and tourism roots; role of the natural environment; healthy offer for locals and tourists; reshaping the public space; and wellbeing defining the destination. The findings and discussion are guided by the following questions:

- Do place characteristics influence synergies between wellbeing, public health and tourism?
- What engagement experiences contributed to synergies between wellbeing, public health and tourism?

8.2 Understanding place through health and tourism roots

Health embedded in history

The birth of tourism

Participants with both public health and tourism departments acknowledged the connection between the pursuit of health and the birth of tourism within the town. Pine trees were often mentioned by participants, who shared how the trees were historically associated with a remedy for breathing difficulties. Ella, a member of the tourism department shares her views of why people historically travelled to this seaside town:

"There are a lot of pine trees, so it was seen as a very good place for people with breathing difficulties. So a lot of spas and hotels grew up to accommodate the people who were travelling to be down by the sea and have a break from the hectic life that was in London, and that was the beginning of the tourism industry."
(Ella)

Historical research similarly reveals that the town had, since the 1870's gained itself a reputation of being a health resort (Nunn 1906). Historical research supports the connection between the Victorian growth of the seaside resorts and the white collar demand for health-related recreation opportunities (Walton 1981). However, it is also contended that from an early stage, the railways also ran cheap trips to the South of England, opening up seaside travel to the masses (Gilbert 1939). It is contended that the emergent working-class seaside holiday diversified demands for leisure activities, attracting tourists who sought pleasures from the beach as well as the beer house (Walton 1974).

Similarly, at the decision-making level, a local councillor also described how the town developed as a tourism destination, Noah shares:

"I am sure you know that [the town] grew up as a tourist place but one of the main things was health wasn't it...and that doctor..who visited the pine trees" (Noah)

In the same vein, Gilbert (1939) contends that the origin of the early development of seaside towns was due to eighteenth century medical professionals advising their patients to visit seashores for their health benefits. Historical reports also support study evidence, where the town has been credited with the value of its pine trees as early as 1906. Historical records reveal that the town's medical officer connected pine trees to being a wind screen, an aseptic respirator and providing a healthy influence to the town's climate. He further underscored the importance of maintaining these pine trees as part of the town's legacy (Nunn 1906). Further archives also reveal that Dr. Russell prescribed that his patients drink the seawater as well as bathe in it. From this perspective, bathing in the sea was not seen as a pleasure but, rather as a medicinal bath. It is suggested that there are many places that flourished as resorts as a result of

them being chosen by court doctors as places that royals may improve their health (Gilbert 1939).

Findings highlight that participants either with the tourism department or elected into local council highlighted the historical connection between tourism and health within the town. Additionally, study findings seem to indicate that at different levels of government there is the acceptance of the notion that visitors come to this area because of the potential health benefits thus, honing in on some of the means to optimise health and wellbeing, a potential area of engagement between local government departments.

Role of tourism

Study participants also highlighted the central role of tourism to the fabric and make-up of the town. Jacob, a member of the local council, shares:

Town identity

"Tourism is very central to [the town], it's a huge part of the town" (Jacob)

Participants, particularly with the tourism department and the elected members of council, comment about how there is a sense of pride and that the area seems to command both domestic and international attention, Max a member of the tourism team suggests:

"you know at the end of the day this is the main bit of public space for the town, this is our golden five miles you know, shop window to the world..."we're quite an innovator and one of the market leading seaside resorts in the country" (Max)

These findings would seem to indicate the pivotal nature of tourism within the town and would suggest that there are many within the local government that feel a sense of pride about the area where they live and work.

Seasonal swell

Participants in the study, from both government departments revealed some of the impacts that the tourism industry has on the town. Jacob, a local councillor, describes how the town may have more facilities and services due to the tourism draw of the seaside destination:

"For a town our size we punch a little bit above our weight because we have a long coastal strip that attracts people in" (Jacob)

Relatedly, one of the issues questioned by a member of the public health team is about how the infrastructure can cope with the influx of visitors to the area, Evie ponders:

"It's a town that doubles in size in the summer...how on earth does that infrastructure cope with that" (Evie)

The literature reviewed appears to challenge some of the study findings where many researchers contend that the support for the economic benefits derived from tourism can be eroded when tourists negatively impact daily patterns of life (Ryan et al. 1998; Doxey 1975). Within the context of this study, participants were all employed, to some extent, by virtue of the strength of the tourist economy thus, this may or may not be echoed by local residents that live near main tourist attractions within the town.

There are numerous studies that suggest that locals have predominantly positive attitudes towards tourism as they associate it with a tool for economic development (Gursoy et al. 2002). However, it is further contended that residents' perceptions of tourism impacts and their support are linked to the destination's stage within the destination lifecycle (Gursoy et al. 2009). If a destination is in the stagnation phase of the tourism lifecycle, then there are more negative attitudes towards mass tourism and tourists (Butler 1989).

Past research into host perceptions of tourism, has historically been focused on the economic impacts (Walpole and Goodwin 2000; Liu et al. 1987). Similarly, many of the respondents from the local tourism department cited how the town economically benefits from the tourism industry through greater infrastructure and service developments. The social dimensions of tourism have only more recently been a greater focus within the research agenda (Brunt and Courtney 1999), where the majority of these researchers employ the social exchange theory to investigate the topic (Gursoy and Rutherford 2004). The main principle of the social exchange theory is that people are more likely to participate in a social exchange when they perceive that they will accrue benefits without unacceptable costs (Gursoy and Rutherford 2004). From this perspective, if locals perceive that the benefits are greater than the costs, then they are more likely to be involved in the exchange and to support future tourism development (Allen et al. 1993).

There are potential areas of alignment between team members in public health and tourism. Within the study there were many participants who perceived tourism as being central to the town's identity. Additionally, there is a mutually acknowledged historical connection between health and tourism traced in the town's historical roots. The town is recognised as a market leader, potentially offering some of the market share to be spent on the development of facilities and services that may better serve tourists as well as the local population.

The dual development of tourism for both health and pleasure may be a means to understand resistance to synergise strategies between tourism and health departments within the local authority. Health practitioners questioned how the seaside town could withstand a doubling within the summer months, questioning the social and environmental costs. In building a healthier tourism offer both health and tourism teams

may be interested in the reduction of binge drinking and promotion of alternative forms of tourism product.

Diversity of perceptions

The findings from this study revealed the wide range of perceptions that are held about the town where respondents described the area from being the happiest place to being overcome with out of control teenagers. A member of the tourism team, Ella, mentions that she believes that the town is evidenced to be one of the happiest places within the UK:

"I think [the town] is one of the happiest places to live, officially" (Ella)

Happiest place in the UK

Predominantly, participants with the tourism team mentioned that they believed that they had heard that there was a study indicating that the area was the happiest place to live within Britain. That said, the criteria with which this was determined was not known, nor the main catalyst for the study being conducted.

Victorian lady/ teenagers out of control

In another vein, Max a member of the tourism team reveals the often contrasting views of the town that are held, where it is perceived to be a bit traditional or old fashioned, he suggests:

"You know people around the country may have perhaps a slightly negative view of what [the town] is...a bit sort of old fashioned, a bit like a Victorian lady in a crinoline skirt or some people may have a view that it's all about nightclubs and teenagers out of control, that kind of stuff" (Max)

Night time economy

Further addressing the theme of drinking and the night time economy, Jack, a member of council expresses an interest in developing a strategy to zone the downtown area encouraging families to spend time in the area, displacing the 'out of control' night club crowd. He proposes:

"And we are trying to do is create zones around [the town] and maybe squeeze out the element we don't want or bring families back in the evening" (Jack)

Research proposes that natural landscapes are social constructs that are related to specific actions meanings and physical attributes (Low and Lawrence-Zuniga 2003; Morin 2003; Muir 1999) and thus are a result of an individual's experiences and social processes (Klanicka et al 2006). Tuan (1974) and Steele (1981), introduced the broad concept of 'sense of place' which is defined by the meanings, attachment and satisfaction that a group or individual identifies with a particular place (Stedman 2003). Klanicka and

colleagues (2006) findings support Stedman (2003) who purports that the physical environment features influence constructed place meanings. In relation to study findings, it could potentially explain the diverse perceptions held of the same place, as well as the local 'insided' perspective, as compared to that of a tourist or outsider perspective.

Area of deprivation

Insided view

The evidence from this study revealed a focus on a particular area of deprivation on the east side of town. It was interesting that many of the participants in the study both within public health and tourism lived within the area. That said both Ethan, from public health and Logan from the tourism team share their insided perspective:

"I prefer this side, it's more of a village and it's more alive" (Logan)

Within the context of the evidence provided by Logan, the east side of town is referred to as being more alive as compared to the west side of town which he describes as having more of a manicured or tourist-driven feel to it. From a differing perspective, Ethan outlines the impact of negative perceptions about an area on the residents themselves:

"A lot of it is about changing perceptions, I think shifting that perception and changing that focus is really important because all of that can have a negative psychological effect on people that may be living in [area of deprivation] and feel that they don't necessarily have as many choices as others" (Ethan)

Keeping people away

Participants, more frequently with the public health team, share the social issues challenging areas of deprivation and how that may prevent residents or tourists from visiting the area. Ava, shares her view about how some of the negative issues may keep people away:

"because some of the areas they are tackling around drug dependency and alcohol have quite a negative impact on how people view [area of deprivation] and might keep people away" (Ava)

In discussing some of the challenges in aligning public health and tourism goals, Mia suggests how tourists could be interested in areas of deprivation, within the context of this town:

"You wouldn't get tourists in areas of deprivation...you might if you make it a nicer place to be" (Mia)

Potential connection to tourism

In exploring means for areas to be more appealing to tourists, Debbie, from the public health team offers:

"So if those things are tackled and people see less of that on the street then...it will make it a more welcoming place for people to come on holiday" (Debbie)

In light of the study evidence that revealed that study participants from both public health and tourism support the regeneration of an area of severe deprivation by virtue of living within the area, this may be a potential opportunity for strategic alliance. The public health team would see the benefits of improved population health with that specific area and regeneration may lead to a more diversified tourism offer driven by art and culture opportunities.

8.3 Role of the natural environment

Being drawn here by the landscape

When participants were asked about the current levels of wellbeing within the town, invariably the role of the natural environment and its positive qualities were cited. Max, a member of the tourism team shares his view about the draw of the natural environment:

"And I think we are all sort of drawn here by the landscape and the sort of natural environment, that's what the town's about...you've got these fabulous natural environments, you've got limitless sea in front of you, it's this place you come and forget about your worries and things and just sort of relax really." (Max)

The role of the seafront

The seafront was identified by participants to be both a marketable selling point and a positive psychological influence. Logan, when referring to the marketability of the town from a tourism perspective, identifies the seafront as the main, if not the only selling point, he contends:

"So I think the seafront and its location is what [the town] has really got and that's what it needs to utilise" (Logan)

From a different perspective, Max, from the tourism team, connects the sea and being able to have more positive outlook and perhaps greater happiness which he further contrasts with a city environment, he proposes:

"I think that if you can see something positive outside your window...you know coming down here brings a smile to your face.....you're not quite as depressed as people living in city areas I suppose" (Max)

Promoting greater levels of wellbeing

Lewis, a member of the tourism team suggests that the location of the town being next to sea contributes to a greater sense of wellbeing:

"I would say that [the town] as a whole feels like a place that has a pretty good sense of wellbeing..being next to the sea, promotes a sense of wellbeing in a lot of people" (Lewis)

Ella, a member of the tourism team connects the sea breeze to greater levels of health, where she shares:

"We live by the sea..it's better because people are healthier here because they have the sea breeze coming through" (Ella)

Aside from archived reports, there is very little current literature which specifically connects seashores or sea breezes with greater levels of health or wellbeing. In a general sense, natural environments have been connected with positive health outcomes but the focus tends to be on the role of green spaces and park areas. Thus, there remains a gap in research around the role of seaside environments and their potential role in health promotion.

Activities in nature

Evidence from this study, also connects participation in activities while in the natural environment as being a positive influence on an individual's wellbeing. Jacob, a member of local council shares his views about the wellbeing connection to the beach and parks:

"Then there's the very positive aspect of people's wellbeing which is linked to a walk on the beach and we have fabulous parks and gardens right the way around [the town]" (Jacob)

Jacob's viewpoint reveals how nature is valued in connection with population level wellbeing. This is an interesting finding in light of the embeddedness of tourism within the town and influence on economic and planning considerations. From a public health perspective, Ethan suggests that the natural environment may be a catalyst for increasing physical activity levels:

"We are more interested in whether or not they might use the outdoor space and the sort of intrinsic wellbeing, that you get from being in such a fantastic natural environment, to start to change people's habits who might not have been physically active for many, many years" (Ethan)

Several studies have supported the notion that leisure activities that take place within natural settings have both stress reduction and restoration effects (Parsons et al. 1998; Sheets and Manzer 1991). Extant literature also provides support for the potential ways that natural areas may promote public health (Bowler et al. 2003). For example, researchers suggest that a natural environment may provide a site for exercise programmes, in turn promoting greater levels of physical activity (Kaczynski and Henderson 2007).

Kyle and colleagues (2004) argue that people search for environments to recuperate from stressful aspects of their lives and that people have a greater sense of attachment to places which provide a means to escape from daily pressures. Additionally, Ulrich (1983) contends that nature may permit psychophysiological stress recovery through responses to natural environments attributes which include spatial openness and water features. This theory suggests that the perceptions of these attributes produce positive emotional reactions (Ulrich 1983).

The biophilia hypothesis as defined by Edward O. Wilson supports much of the study evidence which connects the seaside environment with greater levels of wellbeing. Wilson (1984) put forward the biophilia hypothesis which is a theory that aims to explain the emotional connection of human beings to other living organisms. The hypothesis is described as the innate human tendency to focus on natural and lifelike processes (Wilson 1984). Further to that theory, researchers additionally contend that an affinity to nature goes beyond living things to include streams, ocean waves and wind (Heerwagen and Orians 1993).

In the last twenty years, research focused on connecting humans' positive relationships with nature, has expanded and provided empirical support for the biophilia hypothesis (Gullone 2000; Ulrich 1993). To this end, it is contended that in regards of the topic of place there are currently unmet research needs and there exists opportunities to design and build healthy places with the goal of health promotion (Frumpkin 2003). Maller and colleagues (2005) also suggest that individuals with access to natural environments are found to be healthier in general than other individuals. Furnas (1979) explains the process occurring when people 'clear their head' while in nature as that which can help to strengthen activities within the right hemisphere of the brain and restore functioning of the whole in general.

Bowler and colleagues (2010) suggest that natural environments may have intrinsic qualities which contribute to health and wellbeing. For example Kaplan and Kaplan's (1989) attention restoration theory proposes that nature offers a certain environmental stimuli that allow restoration from attention fatigue. Cumes (1998) has additionally suggested that entering the natural landscape may be therapeutic and include outcomes of: greater self-awareness; greater sense of comfort and connection to nature; an increased appreciation of others; and a feeling of renewal and vigor. Echoing study findings, Hartig and colleagues (1991) found that in comparing a walk in a natural environment, a walk in an urban environment, and relaxing in a comfortable chair, that mental tiredness was best relieved through a walk in a natural area.

In terms of the value of nature and the potential for linking tourism and public health policies, contact with nature has been connected with:

- Pleasant moods (Nisbet and Zelenski, 2011)
- Restoring self-control; (Kaplan and Berman, 2010)
- Attention restoration (Berman et al. 2008);
- Reduced crime and aggression (Kuo & Sullivan 2001);
- Beneficial to human health (Van den Berg 2005; Frumpkin, 2001);
- Reducing mortality risk associated with income inequalities (Mitchell and Popham 2008).

Additionally, Nisbet and colleagues (2014), suggest that nature relatedness remains a significant predictor of the majority of happiness indicators, where nature relatedness may play a more beneficial role in happiness. Henceforth, it is proposed that nature relatedness is a significant predictor of happiness – the assumption being that nature relatedness can cause happiness.

The study evidence has underscored the important role of the natural environment as a means to de-stress and engage in activities promoting wellbeing, is acknowledged by both health and tourism participants. In terms of reshaping behavioural lifestyle patterns, the natural environment is also proposed to play a potential role. In terms of the potential for alliances, the seafront (planned through tourism) may offer planning synergies based on the health benefits derived from engaging in activities within the natural environment and opportunities to improve physical, emotional and mental health states.

8.4 Healthy offer for locals and tourists

When asking participants about the potential for synergies between tourism and health departments from their viewpoint within their roles within the local authority, there were several suggestions from mainly the tourism contingent.

Role of the local population

In the consideration of the role of the local population within the context of living within a seaside destination, Jayden a member of the tourism department shares how he views that tourism within this geographic place is simultaneously consumed by the local population:

"I think that's the nice thing about being a tourism destination, is that you've got a service that local people consume themselves, they can enjoy themselves..and that can make them feel good about it" (Jayden)

Year round resource

Study findings highlight that the views held by participants in tourism seem to more often link to the role of tourism to health and consumption by locals. Max, a member of the tourism team, when discussing his role within the local authority shares his view of how locals benefit from living within this area:

"And also to benefit local residents as well because obviously this is a fantastic natural resource that we have, we are very lucky" (Max)

Similarly, Ella, a participant also employed with the tourism department shares why from a resident's perspective, that it may be a good place to live:

"And I think sometimes residents forget that not many places in the country have that..as a matter of course and they are very lucky to have that kind of offer all year round. So yes, i think my feeling is that [the town] is a very good place to be born and grow up" (Ella)

Artificial war

One of the challenges noted amongst participants was that residents sometimes feel that things are being done for the tourists more so than for the local population. Jayden, a member of the tourism team highlights this point by describing the situation as an artificial war:

"I think getting the local community to understand that things are done for their benefit just as much as the visitors stops you getting an artificial war on almost between the two groups that can get in the way a bit from people just being happy that the whole thing is working for them and the economy" (Jayden)

These findings seem to be explained through the social exchange theory where the main principle is that locals are more likely to participate in an exchange in the case that they perceive that they will experience benefits without suffering any undesirable costs. Thus, in the case of tourism if locals perceive that the benefits exceed the costs then there will, in theory, support future developments within their town (Allen et al. 1993). As there was a mention of the disenchantment of locals, with populations swelling in the summer months, which in turn displaced local populations, this would also seem to be explained by the social exchange theory.

Extant literature suggests that locals may view tourism to be positive or negative based upon its impact of their use resources for recreation (Gursoy and Rutherford 2004). In general, however, it has been concluded that the impacts of tourism generally improve the entertainment and recreational opportunities for the local community (Jurowski et al. 1997). In the evidence from this study it would seem that the participants within the tourism department see the benefits of tourism for locals which may be influenced by the fact that their job stability could be affected by the success of tourism within the town.

Facilities and services

Role of tourist facilities

Study findings also revealed how the role of tourist facilities and services were connected to local wellbeing. Lewis a member of the tourism team shares his thoughts about how tourism can make the town a better place to be:

"Because we have tourist related facilities, that they can also enjoy, it makes [the town] a better place and therefore promotes a greater sense of wellbeing for them" (Lewis)

Tourism promotion and fit for residents

Ella, a member of the tourism team discusses how it would be an interesting piece of research to understand whether tourism promotion does actually improve the health and wellbeing of locals over the longer term:

"I suppose for residents, because the town spends a lot of money and a lot of time, a lot of promotion on making the place pleasant for visitors, it would be interesting to see how that fits residents on a long-term basis" (Ella)

Guaranteed user group

From a different viewpoint, Max, also from the tourism team shares recent survey results that revealed that within the height of summer over half of the seafront users were actually residents. That stated, he further proposed that the trick in tourism planning may be to get the offer right for the residents in first instance:

"Our guaranteed seafront users year round it's the residents and even in the height of the summer..nearly 60% of our beaches is our residents, so if you get the offer right for the residents, then the tourism offer sort of follows behind" (Max)

Recreation destination

In building a destination, participants recognised that many of those participating in the activities on the beach tend to be local residents. Logan, a member of the tourism team describes his perspective:

"Because it is a destination, it's by the sea, it is a recreational destination, they probably have a lot of wellbeing activities..if you look at the usage of the beach, it tends to be lots of local people that do it, it's not just people coming in" (Logan)

From an additional perspective, recreation and tourism have also been identified as agents of change in the landscape development (Palang et al. 2005; van der Vaart 2003; Butler et al. 1998). Thus, it is suggested that the place relations of the residents and their needs are important to development, as are the place relations of the tourists (Klanika et al 2006). Extant literature reveals that there appears to be a gap in empirical studies focusing of tourist place relations as compared to the assortment studies of local's place relations (Manzo 2003; Stokowski 2002). Thus, in comparing and contrasting how the town as a place may be marketed to both locals and tourists, it may be worth greater research into understanding how tourists' perceptions are developed.

Study evidence highlights the potential overlapping of expectations of locals and tourists. For example, locals reveal the importance of the sea in influencing their choice to live on the south coast, despite the high costs of living as do tourists in their choice to vacation

at a seaside resort. In managing expectations of locals and tourists alike perhaps employing the recreational opportunity spectrum may achieve wellbeing objectives and sharpen the tourism offer.

8.5 Reshaping public space

What we want from our public space

When participants were asked about how they believed that the levels of wellbeing could be improved within the town, responses tended to focus on the seafront, the tourism offer; and the importance of the regeneration of specific areas of town. Max, a member of the tourism team connects greater levels of wellbeing to seafront planning phases:

"It's about actually thinking about what we want our seafront to offer in terms of public space" (Max)

A member of the public health team shares how tourism, from his perspective, may have a stronger link to health and wellbeing. Evidence drawn from the interview with Ethan, reveals some of the tourism planning considerations that could help to reshape the tourism offer within the town and further promote levels of wellbeing:

"If you are thinking about defining your future tourism offer, what's different about the town, how are they going to shape that? How are they going to sharpen it?...they could really start to differentiate that tourism offer and link it a bit more strongly to wellbeing" (Ethan)

From a different perspective, Lucy from the public health team speaks about how levels of wellbeing could be raised if areas of deprivation could be a focus of regeneration efforts led by council. Within the town that is the focus of this study, there is one area, on the east side of town, in particular that was cited to be a challenge on several levels. Lucy describes the intent of council around this particular area of town:

"That's where we are going to be trying to raise that level of wellbeing in that area which could raise the level of the whole area up" (Lucy)

Improving the public realm

Approached from tourism and public health perspectives, ideas about how the public realm could be improved upon ranged from basic level surface improvements to changing the people that live within a particular area, through the process of gentrification. Max, from the tourism team describes how simple surface level improvements may change the type of experience for visitors and tourists to the seaside:

"Just on a more basic level, improving the public realm, the public space so you know everything from resurfacing, to lighting, to benches, to bins and things like this. It just creates, enhances the experience" (Max)

From another perspective, Isabella, from the public health team, describes the role of residents in shaping the local offer. Making reference, to areas of deprivation within the town and how these places may be reshaped, she makes note of two potential solutions:

"The place is ever a manifestation of its residents....where you can shape a place by its local offer. You can either improve the health of the people that live there or you can change the people who live there, I am not saying one way is right and one way is wrong." (Isabella)

Potential for regeneration

In further exploring the potential means to reshape place within an area of deprivation, Ava, with the public health team describes her perception of the connections between improved housing conditions and levels of wellbeing:

"So what we knew about [area of deprivation] was that the state of housing , well there were a lot of poor housing conditions....so if you move into one of those flats your wellbeing... your health is more likely to decline, or have unsocial neighbours, there's lots of drug and alcohol and prostitution around you" (Ava)

In addition to housing considerations, Debbie from the public health team describes how an area may be rebranded through the promotion of art and culture offers within an area:

"People will hopefully see [area of town] as the type of place to come if you are a bit arty and creative and they go along and see all this interesting art...and start to turn it into quirky artsy kind of place...so it creates a unique feel to it" (Debbie)

There is an acknowledgement with both public health and tourism participants that a place can be enhanced through the improvement of the local offer which in turn may offer a unique selling proposition in the marketing/branding of the destination. Regeneration, would also seem to offer an area for potential synergy for local public health and tourism planning teams and future budget allocations.

8.6 Wellbeing defining the destination

Creation of a wellbeing destination

Evidence drawn from the study revealed that the majority of participants connected wellbeing within the town to the historical roots of the town's development as a seaside resort. Logan, a member of the tourism team described the early development of the town as a wellbeing destination:

"Its creation was really wellbeing because the first house that was built in [town] was so people could get out of smoky London and come down to enjoy the fresh healthy sea air. So it started off being a wellbeing destination" (Logan)

In further redeveloping the town as a wellbeing destination, Logan further noted that one of the main requirements to achieving this goal is investment:

"I think there is a need to have an investment, to make wellbeing be more a wellbeing product" (Logan)

Promoting wellbeing

Many of the participants that were interviewed, both from public health and tourism teams, connected the sea and coast to levels of wellbeing both individually and amongst the local population. When asked about wellbeing levels within the town and how they may be improved upon, Lewis a member of the tourism team revealed his perception of the link between wellbeing and the town's location on the coast:

"I would say that [the town] as a whole feels like a place that has a pretty good sense of wellbeing..it probably has a lot to do with its location on the coast" (Lewis)

Max, also a member of the tourism team describes where he perceives community wellbeing to lay:

"I wouldn't mind betting if you asked most people in [the town] where they felt wellbeing lay, in terms of community, somewhere in their answers they would say being near the sea and the beach is definitely positive" (Max)

Whilst the sea and coast are most often cited to be where wellbeing rests for most of study participants, parks and open spaces were also highlighted as a place that contributed to citizens' wellbeing. Noah, a member of the tourism team shares his perception of the role of parks in community wellbeing:

"You've got to keep the parks and open spaces up to standard because that is very much the wellbeing [of the town]." (Noah)

Redefining prosperity

In terms of the connection between tourism and health and wellbeing, tourism team members would often speak of destinations in terms of economic benefits to the town whereas public health participants would identify the potential for a healthy destination. Jayden, a member of the tourism team, suggests how he would define prosperity with the town and how it is connected to the local population's wellbeing.

"And then for the destination, we've always said that it's about the prosperity, about a prosperous, it's about a health destination what actually isn't just that it's about economic health it's about the wider, is it helping to contribute to people's happiness and wellbeing" (Jayden)

Study evidence would support the potential for the town to be branded as a wellbeing destination and both tourism and council members recognise the town as ultimately a wellbeing destination. Study findings also reveal the pivotal role of the location of the town on the coast and its perception of contributing to a sense of wellbeing which is a

shared understanding between communities of practice. The continual need to rebrand, that was mentioned particularly by members of the tourism team, may provide the impetus to consider wellbeing destination planning, which may involve representatives from tourism and public health departments across the local authority.

8.7 Conclusion

This chapter has examined the context of place as a means to promote a strategic alliance between local public health and tourism departments. The categories of: understanding place through health and tourism roots, role of the natural environment, healthy offer for local and tourists, reshaping the public space, and wellbeing defining the destination each provided evidence to contribute to the understand of how wellbeing, public health and tourism could be synergised within local government. Study findings and discussion were also guided by the following questions:

Do place characteristics influence synergies between wellbeing, public health and tourism?

What engagement experiences contributed to synergies between wellbeing, public health and tourism?

Study evidence highlighted how the historical roots of the town's creation have bearing on current planning challenges and strategies, the area was originally popularised for both its seaside health benefits and also for its beer houses. Currently, while there is an interest in promoting a healthier or wellbeing tourism destination there remains a thriving night-time economy which features excessive alcohol consumption. Similarly, study findings highlight the diversity of perceptions that are held about the area which range from the "happiest place in the UK" through to one that is "all about nightclubs and teenagers out of control". Furthermore study findings acknowledge that areas of deprivation and the associated negative health behaviours have a negative impact on tourism. Thus, one of the areas of potential synergy between public health and tourism may be around interventions to curb alcohol consumption and regenerate areas. Findings drawn from public health and tourism data, underscored the significant role of the natural environment, seaside, in promoting physical and emotional wellbeing. The health benefits of experiencing the natural environment provide an avenue for co-located wellbeing interventions that benefit residents and tourists alike. Study evidence highlights how the promotion of a wellbeing destination may improve the local area through regeneration efforts in turn offering a rebranding opportunity. Chapter 9 will examine the strategies emerging from study evidence that may contribute to building alliances between public health and tourism.

9. FINDINGS AND DISCUSSION: ENGAGEMENT STRATEGIES

9.1 Introduction

Study participants identified four main strategies to catalyse synergies between the concept of wellbeing and public health and tourism departments within the local council, most often referred to the notions of: a wellbeing vision; a seafront strategy; engaging with community and sharing knowledge. This chapter will critically assess the value of each of these emergent themes as potential boundary objects and examine the relative merits of each as a tool to synergise health and tourism communities of practice through wellbeing. The findings and discussion for each of these categories will seek to understand how boundary objects and boundaries may help to facilitate learning and the transfer of knowledge at both individual and organisational levels, see chapter outline within Figure 17. A review of extant literature reveals that the processes that may facilitate learning across communities of practice are still not clearly understood (Mørk et al. 2008; Van der Vegt and Bunderson 2005). Building on Star and Griesemer's (1989) original definition of boundary objects, Bechky (2006) offers that they provide palpable definitions which can help in creating a common ground for communication, which can promote local understandings to be contextualised, creating a transformation of understanding that is necessary for knowledge to in turn be shared. Guided by Bechky's working definition of boundary objects, this chapter seeks to further develop understanding of how learning may be bridged across public health and tourism communities of practice through the concept of wellbeing.

The findings and discussion within this chapter will also be evaluated in terms of the following questions:

- What strategies were used to synergise public health and tourism communities of practice?
- What are the consequences of these strategies?

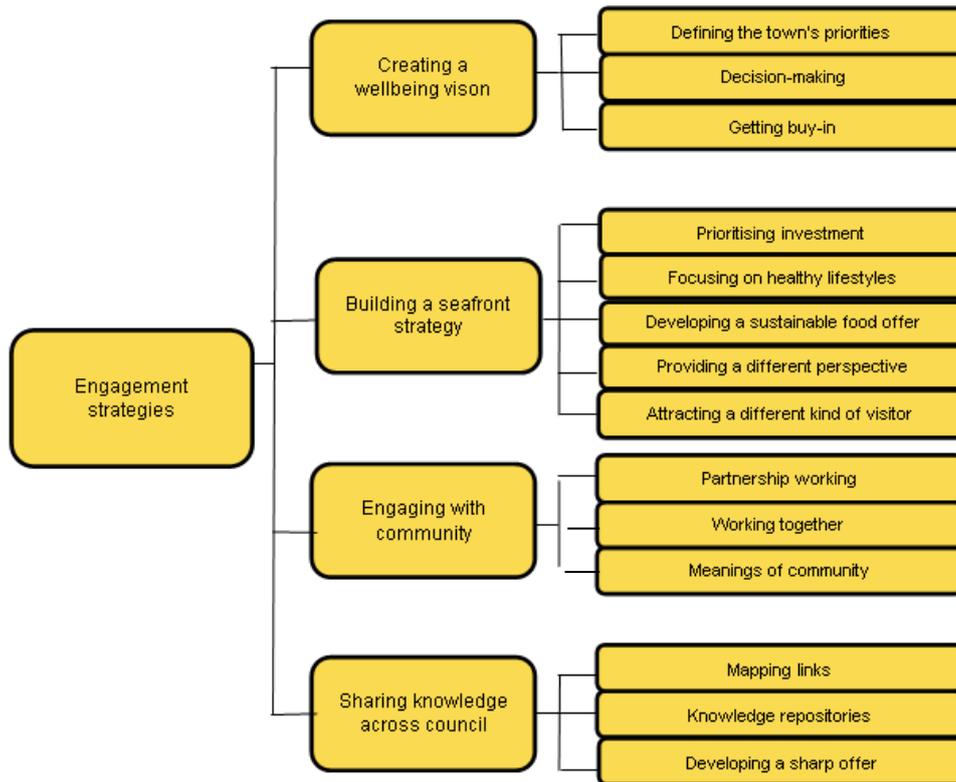


Figure 17: Framework for engagement strategies chapter

9.2 Creating a wellbeing vision

Defining the town's priorities

Consultation

The majority of participants, when describing the use of wellbeing within their job roles, would link the concept to the development of a set of priorities or a framework. Members from the public health team outlined some of the preliminary steps involved within the development of a wellbeing framework. Ava shares the main priorities that were identified within a local planning process:

“the priorities that came out of [our] consultation work... focused on the town’s economic, social, environmental wellbeing... the wellbeing of the town and the wellbeing of its residents...they just happen to be our priorities right now” (Ava, Public Health)

In this example, Ava’s main work priorities are underpinned by the aim of achieving economic, social and environmental wellbeing in the town. In the interview conversation with Ava she mentioned that discussions to date had mainly been with members of council within the public health team and related cabinet members. The nature of their

identified work priorities tended to align their tasks more with the housing department than with the tourism department. Project aims mainly involved the local population and the issues of health inequalities, which were being targeted through regeneration initiatives focused on youth populations. While there were possible indirect links to tourism, any overt shared priorities had not to date been identified at any collaborative forum.

In reflecting on the potential for collaboration, Ava recognised the wellbeing vision as a potential area for the town to work together:

“It’s sort of an overall vision for the town. Where hopefully we all work together collectively as a town to work on the kind of key issues affecting the town at the moment.” (Ava, public health)

This evidence would suggest that there is the acknowledgement of a need for collaboration in striving to achieve wellbeing priorities. However, future project planning processes and outcomes will reveal whether or not truly collective efforts were, in practice, fully achieved.

In the interview conversation with Ava she described how the process of consultation led to the town’s priorities and her work projects being defined. From a different angle, Daniel shares how consultation processes with internal and external stakeholders led to the development of the regional wellbeing strategy:

“So there is a consultation exercise that involves what the priorities should be [involving] local people and local stakeholders and you come with a sort of wellbeing strategy” (Daniel, Public Health)

Within the interview with Daniel he described how, from his perspective, the region would arrive at a wellbeing strategy. He described the process as being complex in the sense that there were many priorities that were identified across the consultation table, where it was not possible from a strategic perspective, to address all of the health concerns that were brought forward. Despite these noted challenges, the process of building the wellbeing strategy, arguably became a way for internal and external stakeholders (including local public health employees) to engage at different boundaries and facilitate levels of engagement through the boundary object of ‘the wellbeing strategy’. Interview data gathered would suggest that this process of consultation was often quite contentious as not all priorities could be included within the actual strategy however; it was effective, in that the main challenges to wellbeing were identified and the main priority areas were drawn from the existing evidence base.

Positioning health and wellbeing within the council

Similarly, other members of the public health team described the process involved in working towards the goal of council becoming a wellbeing organisation. Participants all

highlighted the current team priority to engage with all of the other directorates in order to identify the location of potential links to health and wellbeing. Ethan, with the public health team shared one of his team's first priorities:

“And we are starting to develop a health and wellbeing framework for the council”
(Ethan, Public Health)

One of the methods of engaging with directorates across council was through the ‘public health development forum’ that was set up when the public health agenda moved across to the local council. The public health forum meets every couple of months and is attended by service managers from directorates across council. Ethan describes how the forum provided an opportunity to forge links between public health and tourism:

“At the last meeting we had a presentation with one of the seafront strategy team...who’s been involved in developing the seafront strategy... which was really good because I think he spotted straight away the potential for the development of the seafront strategy to incorporate opportunities to improve health and wellbeing.” (Ethan, Public Health)

Ethan reveals the potential role of the public health forum in facilitating knowledge transfer across different departments. With the move of the public health agenda moving into the local authority, there would appear to be a greater need for boundary crossing between different disciplines further requiring a framework to bridge philosophical, theoretical, and practical schools of thoughts from various departments (Keshkamat et al. 2012; Rotmans 2003). Echoing the findings from this study, literature reviewed reveals that within the context of project management, boundary objects are recognised as a means of promoting and sharing knowledge between diverse groups (Yakura 2002; Brown and Duguid 2001). Within this specific situation of employing the wellbeing construct at the public health development forum, the forum itself can be viewed as an entity that may improve the capability of an idea, theory or practice to in turn translate across boundaries between communities of knowledge or practice (Wenger 1998; Brown and Duguid 1991). Wellbeing as a concept within the local government would seem to have the desired vagueness to make it effective in facilitating communication and cooperation between members (Allen 2009). Boundary objects that are only a single word, akin to the concept of wellbeing, are contended to be effective in enabling syntactic coordination and the process of information transfer (Carlile 2002). The main aim of the boundary object concept, wellbeing in this context, is that it offers a way to bridge differences between diverse communities of practice through shared knowledge, goals and strategic direction.

In terms of a potential avenue to share understanding and knowledge, the public health development forum offers a means to synergise directorates across council in a dialogue around wellbeing. The public health development forum in itself, may act as a facilitative

boundary object as it offers an opportunity for knowledge to be shared across boundaries. Research findings suggest that boundary objects tend to be more facilitative when the communities of practice share both a common syntax (Carlisle 2002) and common motives (Wilson and Herndl 2007). In the case of the public health forum it could be argued that while there is a common syntax the motives may not be common. The members of the public health team outlined that it was their directive to embed wellbeing across council directorates. Conversely, the members of the public health forum from directorates outside of public health may not see a common interest or find a motivation to include wellbeing considerations within their individual and group mandates and work tasks.

The public health development forum may provide opportunities for discussion to occur that reveal the need to exchange knowledge (Wilson and Herndl 2007) and in turn serve as a means to establish a common language where knowledge and meaning can be shared (Carlisle 2002). Reviewed literature also underscores that face to face interaction is fundamental to the transfer of complex knowledge across boundaries (Sapseed and Salter 2004; Storper and Venables 2003). Carlisle (2002) stresses that it becomes more difficult to communicate (locally entrenched) embedded knowledge used when there is a distance between one another's practice (Sapseed and Salter 2004). It is also put forward that co-located groups tend to better share knowledge than dispersed group members (Scarborough et al. 2004; Kiesler and Cummings 2002;); where colocation is identified as being significant to project team members' knowledge integration (Galegher et al. 1990). The nature of the public health development forum demands colocation for each held meeting. Additionally, both the public health and tourism departments are both located on the same site at the Town Hall location, which may bode well for future project collaboration.

The ultimate goal of public health team members seemed, at the time of interview, was to have public health embedded across the organisation rather than the service being viewed as an add on to the existing directorates. In that vein, Mia conveys her views:

“Public health is all encompassing and so it runs through every single directorate in the local authority and wellbeing therefore runs through every single directorate... but, probably quicker than I realised...public health is slowly integrating with all of the directorates” (Mia)

In speaking with participants from public health they consistently highlighted the point that health and wellbeing are embedded within the priorities of every directorate and as such ought to be considered in every decision being made across the planning table. This priority of the public health team necessarily demands work at knowledge boundaries between different communities of practice. Star (2010) and her collaborators

hold the perspective that boundaries are not viewed as acting as a divisive force or markers of difference but, rather act as an interface that may facilitate the production of knowledge (Lamont and Molnar 2002). Study findings similarly reveal different types of boundaries that need to be crossed in order to achieve departmental priorities. This may present opportunities for learning as it is suggested that boundaries may serve as a device for bridging, exchange, communication and potential inclusion (Bryson 1996; Peterson and Kern 1996).

Means to integrate wellbeing into leaders' agendas

Findings drawn from the interview with Daniel, reviewed a potential means for leaders to engage with the wellbeing framework:

“You need to have a read across your key strategic documents ... if you are engaging people with different agendas... when you are talking about the leaders, you need a read across [the] conurbation” (Daniel, Public Health)

From a more regional perspective, Daniel shares his thoughts about how leaders may be able to engage with the wellbeing construct and potentially find the overlap to their own job priorities. From the public health perspective wellbeing as a concept has always been embedded in the work of council directorates and one of their primary tasks is to embed the health agenda right across council. Study evidence reveals that there are both potential avenues of convergence as well as divergence in the case of wellbeing facilitating synergies between public health and tourism. Extant literature highlights that two of the prominent features of boundary objects is that they have interpretive scope and flexibility (Spee and Jarzabkowski 2009; Star and Griesemer 1989). One of the distinctions that is emphasised is that boundary objects need to be meaningfully and usefully integrated into the work practice of actors in diverse fields. Interview data drawn from public health and tourism participants reveals that there may be some resistance from directorates outside public health, namely council members who incidentally could in an ideal world, act as successful brokers of knowledge sharing.

Decision-making

Not being the principle promoter of tourism

Study findings revealed some of the factors to consider in decision-making related to wellbeing, public health and tourism. One of the participants' mentions how there is a level of caution in the decision-making within council as the tourism industry within the town has a large independent sector to consider:

“council has to be careful of the role it plays because we're not the principal promoter of tourism as it is a large independent sector there's hoteliers, the conference and convention sector, the night-time economy and there becomes the questions of how that contributes to our wellbeing” (Jacob, Public Health)

Jacob (Public Health) reveals one of the primary challenges to the town's decision-making is the large role of external stakeholders in the town's tourism industry. This presents some potential challenges, where external stakeholders may be contributing to the tourism offerings and subsequent revenue but, their goals may be counterintuitive to wellbeing goals established by internal stakeholders within council. In that vein, council would not want to enforce guidelines that are so strict that it drives away primary tourism promoters. Another consideration relates to how the concept of wellbeing would be interpreted by external stakeholders and whether or not the tourism department would use the concept in a similar manner to meetings and forums with internal council stakeholders.

Intentionally blurry boundaries

Another noted consideration is around how cabinet members' portfolio structure was originally designed with the idea of collaboration in mind:

“when I set up this structure I did it so there are areas where they are not totally defined edges to portfolios which forces two or three portfolio holders to work together on some things” (Joshua, Tourism)

Carlile (2002) proposes that there are three types of knowledge boundaries that each present varying levels of challenge: syntactic, semantic and pragmatic. The boundaries to be crossed within the context of this study could be defined as pragmatic as there is the greatest social and political complexity and the mutual interests are still in the process of being developed to potentially 'transform' knowledge at the pragmatic boundary (Carlile 2004). Research supports the notion that boundary objects may promote the transfer, translation and transformation of knowledge across pragmatic boundaries. Similarly, study evidence reveals avenues for the potential transfer, translation and transformation of knowledge across portfolio boundaries of council cabinet members in this example and across communities of practice.

Widening scope for wellbeing dialogue

A participant that is involved with the tourism advisory board recalls how greater inclusion was demanded within their decision-making process:

“It was recommended at the meeting that the health cabinet member be involved because it was health, its part of wellbeing” (Logan, Tourism)

This study evidence reveals how wellbeing as a boundary object may facilitate greater inclusion and ultimately collaboration. Leonard (1995) proposes that one of the key ingredients of competitive advantage is working across boundaries between disciplines, as it is suggested that this is where innovation happens. It is contended that all learning will involve boundaries (Akkerman and Bakker 2011) where there are four potential

learning mechanisms that can take place: identification, coordination, reflection and transformation (Lave and Wenger 1991).

These learning mechanisms outlined by Akkerman and Bakker (2011) present a framework to understand the potential of knowledge operating at the boundaries. Identification in this context refers to the boundary crossing that may lead to identification of overlapping practices; in turn it is proposed that practices become redefined by nature of the existence of one another. Coordination refers to a minimal number regimented exchanges being set-up in order to enable a smoother transition. Reflection refers to the impact of boundary crossing that enables learning about a practice through the lens of the other practice. Transformation refers the changes in practices that occur in light of boundary crossing and may refer to the creation of a new hybrid practice, a boundary practice.

Study findings predominantly describe the learning mechanisms of identification, coordination, and to a lesser extent, reflection. Findings drawn from the interview with Joshua indicate that he has identified the importance of boundary crossing which may lead to overlapping processes, evidenced by the act of his setting up blurred boundaries for cabinet portfolio holders. Parallel to claims within the literature, Joshua would also seem to recognise that boundaries are spaces that offer a potential for individual and organisational learning (Akkerman and Bakker 2011). In terms of his role and those of cabinet members, directors and managers, it is proposed that there are some leaders that tend to be successful based on their boundary-crossing leadership style (Morse 2010), those that advocate for the promotion of boundary crossing competence that rests upon the ability to effectively manage diverse discourses and practices across boundaries (Fortuin and Bush 2010; Walker and Nocon 2007).

Getting buy in

Understanding employee focus

Reflecting on some of the challenges to getting buy-in across council for a collective wellbeing strategy, participants from both public health and tourism shared their perspectives. Jayden (Tourism) views one of the main constraints to be, how people view their job roles:

“It’s more an effort than perhaps it should be to get that to happen but, I could understand why people focus on 90% of their job versus the 10% bit” (Jayden)

Relatedly, Simon (1957) puts forward that one of the challenges faced by potential knowledge brokers is that they operate within a world where people are information satisficers rather than optimizers, often applying the first bit of information that will work (Snowden 2006). It is further contended that people employ a just-in-time approach to

knowing things, in that people tend to be more willing to respond to requests for information to satisfy an identified need rather than having a knowledge exchange in anticipation of a need (Snowden 2006). Findings drawn from Jayden's interview reveal potential challenges to asking employees to consider information that is either a small part of their remit or acts as a mere extension. Interview data suggests that if there is not a strong incentive for employees to cross boundaries and engage in collaborative projects then, there will be little motivation to engage in such activities. Similarly, Logan (Tourism) describes how the silo approach within organisations impedes the potential for learning.

"We are used to being in departments or compartments we look after our department or compartment, it doesn't utilise the best of the resources in terms of achieving the overall objective. You can have lots of departments running well and efficiently and not achieve what you want to achieve" (Logan)

The challenge of silo working is not new; the theme of tackling disciplinary and sectoral silos is echoed within nearly all health related research (McDonald et al. 2007; Clancy 2006; Mann 2005). It is further contended that the success of health reform rests on being able to substitute fragmentation and waste for coordination and cost-effectiveness (Kreindler et al 2012). In the current political climate, any cost saving measures may free up budget allocation to be used towards effective programme implementation. Where boundary objects and boundary learning present potential means to achieve these savings.

Trying to get a paradigm shift

From a public health perspective, Daniel shares some of the potential constraints associated with getting buy-in across council and getting staff to actively address some of the more complex problems being faced within the town:

"You need the buy-in into the process...it can be difficult to engage...I think you have to spend time on that... And I think if you are trying to get a paradigm shift around others like obesity and alcohol, we've got some way to go yet" (Daniel)

While Daniel does not explicitly share how to get buy-in into the process of making council a wellbeing organisation, he does stress the importance of spending time on working to engage staff members. He refers to the challenge of trying to get a paradigm shift in terms of how the organisation approaches major health risks, he refers to as wicked problems, like obesity which runs parallel to past literature which proposes that the more radical the desired innovation, the greater the risk of encountering problems in negotiating across boundaries (Christensen et al. 2000).

One of the additional challenges suggested in the literature is that the success of knowledge sharing rests on whether or not there is a shared worldview held by members

of different communities of practice (Clark and Brennan 1991), where a heterogeneity of worldviews can often lead to misunderstandings (Koskinen and Mäkinen 2007). It is put forward, that when there is a shared context, it becomes possible for perspective taking to occur through boundary objects. For clarity, ‘wicked problems’ are problems that do not have a clear or agreed definition (Conklin 2006; Kuntz et al. 1972) and are argued to require a large amount of social interaction in a variety of forms (Koskinen 2009). Study findings highlight the need for wicked problems to be addressed within the public health agenda, thus demanding a great deal of social interaction and perspective taking.

Balancing effective public health with politics

“I am just telling you sometimes trying to balance effective public health with politics within the local government, particularly in the current climate again huge pressure financially they have to make big savings. I am not sure the two will go hand in hand. There is a lot of sensitivity around all this. I think it is our job, to brief these members, particularly the member whose got the portfolio for public health so they understand really well what we are about and that...we are adding value you know, and that the initiatives are good value or not. But, it’s a fine line because if it loses them votes at the end of the day” (Mia, Public Health)

The interview with Mia underscored the struggle between delivering effective public health programmes within the climate of local government politics. One of the challenges is that local councillors are not likely to engage in initiatives that will make them unpopular in their ward. Mia perceived this challenge as being one of the largest within her new remit with local government. In this context, the flexibility in meaning of the concept of wellbeing may or may not be helpful in bridging communication. In the case of the council member who did not want to lose any votes, there is an opportunity to persuade said member that the concept of wellbeing may actually enable them to win more votes as the object’s flexibility is paramount to the process of sense-making by different groups (Sapseed and Salter 2004; Henderson 1991).

9.3 Building a seafront strategy

Prioritising Investment

In discussions around potential synergies between public health and tourism, the seafront strategy was mentioned most often as an avenue for current and future interdepartmental collaboration. The development of the strategy was cited to be a work in progress that had begun more than two years prior to interviews for this study being conducted. It was noted to be an exercise that would focus on:

“Working out how we are going to prioritise investment across the seafront over the next 20 years”. (Max, Tourism)

Max, an employee with the tourism department spoke about some the financial challenges in maintaining the existing infrastructure on the seafront. In terms of the main priorities, he discussed the difficulty in keeping the current infrastructure in working order due to the impact of the harsh winter weather, the salinity of the seawater and the abrasive sea winds corroding existing structures. That said, a large portion of the council's budget is required for the seafront maintenance as the seven miles of seafront, is viewed to be the main tourist attraction and draw to the area.

In looking at investment priorities in the next 20 years, this may offer a means for different departments to play a role in exploring overlapping areas of work priorities. In the review of interview data from the conversation with Max, he described how he had presented the plans for the seafront strategy to the public health forum and outlined some of the ways that the strategy may meet wellbeing objectives.

"I have only attended a couple of meeting so far, my presentations have all been about, this is where we are at, this is our stall, this is our strategy, there's an opportunity to work with you guys around the health agenda" (Max, Tourism)

The interview with Max highlighted how there were the beginnings of a conversation between public health and tourism employees involved in the planning of the seafront strategy. He further mentioned that tourism staff members were open to having conversations about collocating tourism and public health agendas in the phased approach to developing the seafront.

Later in the interview with Max he highlighted that a high percentage of seasonal users on the seafront were actually residents further emphasising how the public health agenda may have parallel interests to the seafront strategy.

"But, you know what are our guaranteed seafront users year round it's the residents and even in the height of summer, you know nearly 60% of our beaches are our residents so, you get the offer right for the residents, then the tourism offer sort of follows behind." (Max, Tourism)

Study findings highlight the potential overlap in developing a seafront offer that will meet the needs of the residents and visitors to the area. Similarly, past research highlights the potential benefits that local communities may experience as a result of tourism development (Novelli et al. 2006; Kay 2004; Worpole 1992). Kay (2004) advises that improvements to infrastructure and the environment would surely create a more positive sense of place identity. It is also suggested that tourism strategies may create jobs and enhance the quality of life for both residents and visitors. It is contended that the starting point for tourism strategies is self-image which would arguably be a concern for both residents and visitors alike (Warpole 1992).

Focusing on healthy lifestyles

Making exercise fun

As part of the seafront strategy, the seafront is being divided into different zones as a means of diversifying the tourism and local offer. One zone in particular is focused around healthy lifestyles and is being called the coastal activities park. Study participants most often connected health, wellbeing and tourism with the planned activities within this activities park. Lucy (Public Health) shared her views about how this zone/park within the seafront strategy is aligned with the public health agenda:

“Part of that is going to be the coastal activities park...where those activities are very much aligned to the public health objectives...there’s a pilot project about who are at risk of diabetes and getting them to do more exercise and make it fun...I think this is the answer for working together” (Lucy, Public Health)

From findings drawn from the interview with Lucy a possible bridge was conceptualised between public health and tourism through the medium of exercise and making it a fun and enjoyable activity. Public health is interested in keeping people healthier, for longer and tourism is interested in finding ways to diversify their offer and finding new ways to entertain their visitors. The specific example that was mentioned by Lucy about the pilot project for those at greater risk of diabetes is a good example of how tourism and public health may be able to work together to develop a range of health activities and programme offers for tourists and residents. Past research also finds that if exercise is not being enjoyed, it will not be sustained (Teri et al. 2008). With the goal of maximising enjoyment, programmes to help dementia participants are designed and adapted to assist participants in selecting activities that they will ultimately enjoy (Teri et al. 2008; Yao et al. 2008). Lieberman (2015) further contends that as a species, humans perform as their ancestors did and exercise only when it is either fun, a form of play or deemed necessary.

Engaging residents

Many of the study participants discussed the drive to find new ways to engage people, in developing an offer for the town that entices people to engage with different areas or activities, to present different pull factors to the area or levers to participation in activities. Within the seafront strategy, the coastal activities park has a specific focus on healthy lifestyles. As Lucy illustrates, the coastal activity park is somewhere that public intervention programmes can be developed with tourism staff. From a tourism perspective, Lewis shares his thoughts:

“You can see obvious synergies with the coastal park and engaging residents in the value of tourism” (Lewis, Tourism)

As a point of engagement, study participants recognised that the coastal park may offer opportunities to be involved in healthy activities that may be suited to both tourists and

locals, and be a means to engage with the public health agenda. Past literature contends that the term 'healthy lifestyle' has historically attracted a great deal of interest from health, hospitality and tourism sectors (Novelli et al, 2006). Douglas (2001) defines a healthy lifestyle as one that deals effectively with health-related elements and activities, diet control, maintenance of stress levels and a positive use of leisure time. Within the seafront strategy, the coastal activity park, may act as a facilitative boundary object simultaneously addressing tourism and public health agendas.

Developing a sustainable food offer

Identifying avenues for improvement

Study findings predominantly discussed the links between the food offers on the beach and wellbeing being rooted in the sustainable food movement and achieving long term self-sufficiency for the town. However, Logan (Tourism) approached the links between wellbeing and the food offer from a different angle, where he contends:

“the paucity of food and beverage outlets along the prom makes it quite stressful I think and goes against wellbeing....So I think there is a need to have an investment, to make wellbeing be more a wellbeing product” (Logan, Tourism)

From Logan's perspective there is a lack of existing food options to visitors or residents that makes it inconvenient when you are in need of food, particularly for families trying to feed their children. More recently, tourism research acknowledges the role that food and drink play in tourism, where two-thirds of Britons reported that food and drink would influence their holiday selection (Lane 2005). In keeping with a health consciousness, people increasingly wish to have access to healthy and tasty food made with fresh regional ingredients (Hallab et al. 2003). That said, it is suggested that becomes essential to exchange ideas and diversify the products and services that are on offer (Novelli et al. 2006) through the formation of groups where knowledge and expertise are exchanged (Carlsen et al. 2001).

Developing a sustainable offer

From a public health perspective, a potential link that was suggested to co-locate public health and tourism agendas is developing something akin to a sustainable food city:

“I'm working on one at the moment which is about, can we develop something called a sustainable food city. And that's all tied to employment, long-term self-sufficiency, the same as energy and I think that's a worthwhile project” (Daniel, Public Health)

Another potential link to resident and tourist wellbeing is around sustainable food sourcing and the types of food that is offered along the seafront. Focusing on the range of food offers available on the seafront, one of the councillors holding the health portfolio

makes reference to one of the restaurants in particular who focus on sustainable food sourcing and how it may be connected to wellbeing:

Examples of locally sourced food

“They sort of have an urban farm and they project the image of healthy locally grown sustainable food and that all fits in environment and health lifestyles”
(Lucy, Public Health)

An additional aspect of the seafront strategy that may co-locate public health and tourism interests is the planning and development of a sustainable food offer on the seafront. From a public health perspective this would be a fit to meeting the objectives around achieving healthy lifestyles and the tourism interest would seem to be linked to diversifying the tourism offer and potentially attracting a new type of visitor to the town. To an extent, it would seem that both tourism providers and public health practitioners have a vested interest in the quality, quantity and diversity of food options on the seafront. As such, the concept of a sustainable food offer may too act as a catalyst for synergising public health and tourism communities of practice.

Providing a different perspective

In the review of the seafront strategy the phased plan is to divide the seafront into different zones where each of the zones is offering a different type of experience to both the visitors and to the locals. One of the ideas outlined within the strategy is to create an elevated walkway, Logan (Tourism) shares his thoughts about this part of the seafront strategy:

Creating different perspectives

“I think those sorts of concepts would be quite good because they allow you to utilize something which isn’t at all utilisable...it would give a different visual perspective of the seaside” (Logan)

Keeping people more active for longer

Additionally, Max (Tourism) shares his perspective of how a natural zone may encourage greater levels of exercise amongst an older demographic:

“It might enhance your enjoyment of going for a walk or encourage more organised walks and trails and keep older people more active for longer....that’s the one area we are actively trying to find ways to work with the public health agenda” (Max, Tourism)

Past research also suggests that regular exercise is beneficial to adults and older adults in terms of improving and preserving the function of their physical wellbeing (Young and Dinan 2005; Taylor et al. 2004; Keysor 2003). More recently, a case has also been made for the connection between increased exercise and improved psychological wellbeing (Barbour and Blumenthal 2005; Biddle and Faulkner 2002; Fox and Stathi 2002).

In addition, natural settings have been connected to health and wellbeing (Hartig et al. 2014; Dinnie et al 2013; Mitchell 2013; Bowler et al., 2010). Pioneering academic literature contends that individuals that have access to nearby natural settings are healthier overall (Kaplan and Kaplan 1989). Research also suggests that walking in a natural landscape, such as a beach, can both stimulate psychological restoration and stress reduction (Hartig et al. 2011; Abraham et al., 2010). In particular, the concept of blue space is linked to health and wellbeing (Finlay et al. 2015). The concept of blue space includes oceans, lakes, rivers, fountains and streams (White et al., 2010). Green space is a term that is used to natural areas like parks gardens and forests (Lee and Maheswaran 2011, Maas et al. 2006). These spaces have been linked to restorative impacts including stress reduction and improved quality of life (Thompson et al. 2012; Maller et al 2005). The proposed elevated walkway within the phased development plan within the seaside strategy presents an opportunity for locals and tourists to increase their levels of wellbeing through being active in both green and blue spaces.

Attracting a different kind of visitor

Developing a wellbeing tourism “offer”

As a potential means of engaging participants from public health and tourism, findings revealed a theme focusing on the considerations around what kind of visitor council may want to attract to the town. In terms of forward thinking within tourism planning, participants often connected the type of visitor that they may want to attract to the area and the type of tourism experience that they would want to have on offer when considering wellbeing and health:

“thinking about wellbeing and health, it’s not just about providing sort of traditional sport or health activities, it’s about finding new ways to engage people that want to be doing something else” (Max, Tourism)

In the development of a different tourism brand or offer, Max (Tourism) frames this quest as a new way to engage people. In a similar vein, Lucy (Public health) shares her views about the types of holidays that she perceives tourists will demand into the future.

Speculating about future demand

Looking forward to the future demands of tourists, a public health participant suggests that there may be greater concern around health and wellbeing:

“I think the kind of activity holidays will be the thing of the future because people are being more and more aware of health and wellbeing and the dangers of...not being very active are becoming more widely spread” (Lucy)

Research within the last decade has highlighted the demand for and provision of wellbeing vacations (Little 2015). Wellness tourism has become the label used to

describe holidays that encompass meditation retreats, fitness holidays, spa retreats and adventure tourism (Atkinson et al 2012; Picard and Robinson 2012; Bushell and Shelton 2009). The growth of wellness tourism opportunities are being connected with the growing importance of health and quality of life and tourists seeking a more meaningful way to spend their vacation time (Little 2015).

Stressing the need for wellbeing vacations

Logan (Tourism), also shares his thoughts about some of the catalysts in the societal context that may contribute to a growing demand for wellbeing holidays:

“when you’ve had an economic recession like we’ve had over the last four or five years, you find that they reduce costs by adding and spreading workloads and some people pick up huge amounts of work load and carry that...and I think that just builds stress and it works against wellbeing and it probably makes the need for proper wellbeing vacations for most people really important. (Logan)

Parallel to Logan’s observation, past research also contends that as people’s lives are increasingly dominated by busy and stressful lifestyles the demand for healthy options increases both in their leisure and holiday time (Keynotes Ltd. 2003; Douglas 2001). These findings coupled with those relating to the seafront strategy show the areas for potential communication across boundaries. Study findings highlighted how different aspects of the seafront strategy may help facilitate meaningful collaboration between public health and tourism communities of practice. The seafront strategy may in this context serve as a facilitative boundary object allowing communication and knowledge share across boundaries around themes such as: increasing the benefits of tourism to residents, exploring health activities and lifestyles within the coastal activity park, developing a healthy food offer on the seaside, diversifying activity offers in green and blue space, and the demand and potential rebranding opportunity for wellbeing vacations.

9.4 Engaging with ‘community’

Partnership working

Within this study, findings highlight the important role of partnerships and collaboration as a means of solving more complex problems and as a means of working more effectively. Daniel (Public Health) conveys the importance of partnership working in challenging financial times:

“People tend to...hone into their own agendas and..you know, because money’s tight, and I think that, if you are going to unlock potential you’ve got to work in partnership.” (Daniel)

Amongst public health participants the increasing complexity involved in dealing with societal health challenges was noted. Whereas the tourism community recognised that the largest challenge was around reinvention and finding new tourism products to attract new visitors to the town. In an effort to develop a wellbeing niche or product there may be an opportunity for public health and tourism communities to forge a partnership to address these priority areas.

Working together

Doing things for the community

One theme that was common to both public health and tourism participants is around the importance of working with a community versus them feeling powerless in the decision-making process. There was a sharp distinction between public health and tourism participants' views about the messages they wanted to convey to community members. Jayden (Tourism) shares what he believes is the most important point for the public to understand:

“So I think that’s quite important that effort is made to involve the community and let them understand that you are doing things for them” (Jayden)

Study findings reveal that within a tourism community, there can often be a very stark divide and animosity between locals and tourists in turn; a lack of engagement with the local community about decisions around destination management can really feel like an imposition. In this example, Jayden seems to be underscoring the need for public information forums that disseminate updates and information. Where this approach has the potential to be a two-way communication process, it does not seem to invite the public into the decision-making process.

Doing things with the community

From a slightly different perspective, the public health work around regeneration in areas of generational deprivation draws out a similar theme.

“it’s very difficult with the kind of work, not to do things to a community, you have to do it with... that really does work in bringing up their aspirations and understanding what could be achieved” (Lucy)

Within this conversation Lucy shares how she approaches meaningful community engagement, where she describes how people within this community can feel a greater sense of worth from feeling that their voices are heard and their views and ideas can make a difference.

Ethan (Public Health) also shares his perspective about involving the local community in decisions about health issues:

“And a bit more flexibility around involving local people and perhaps coming up with ideas about how they could come up with solutions to resolve some of these particularly difficult access issues to health.” (Ethan, Health)

Providing opportunities to work together

Building on the two examples provided, a view was shared about the potential dividends for a town where people are working together.

“I think that the most successful communities are those that work together and are given the opportunity to work together...in many ways it’s up to the local authorities and public bodies to provide those opportunities” (Ella, Tourism)

Extant research reveals the potential value of user and community coproduction within the local authority, where a growing body of literature supports the concept of coproduction as a mechanism which offers a means to improve service delivery (Bovaird 2007; Needham 2007). The concept of coproduction can be defined as the citizens, clients, consumers, volunteers and community organisations involvement in producing public services (Alford 1998). Within the context of the UK, the concept of co-production is gaining a great deal of attention as a means that may improve service provision (Needham 2007; Halpern et al. 2004; Kelly et al. 2002). This approach challenges the adversarial position in consumer relationships instead emphasizing their interdependence (Ostrom 1996). In addition, this approach presents an opportunity to improve service efficiency and effectiveness (Needham 2007). Eroding the boundary between service producers and users may be an approach that would co-locate public health and tourism communities of practice in efforts to create opportunities for the coproduction to potentially optimise service delivery.

Meanings of community

Identifying what’s really important

Many of the participants shared how they viewed the role of the community in people’s lives. For a range of reasons, conversations seemed to centre on the connection between community and building a sense of wellbeing. Findings drawn from the interview with Max reveal why, for him, the concept of community is important:

“It’s how we interact with other people and how we feel comfortable with people in the community that’s important” (Max, Tourism)

Taking part in community projects

In another context, the role of community was also cited as playing a part in developing a sense of wellbeing.

“I think it’s a very basic premise that you feel better if you are helping someone else or taking part in community projects...it gives you a feeling of wellbeing..” (Ella, Tourism)

Cole (2007) proposes that community participation is imperative for gaining community support and acceptance of tourism development projects and make certain that benefits will meet local community needs. Empowerment can be defined as the ability of individual or groups to make choices affecting their own affairs; a process designed to assist people in taking control of factors relevant to their lives (Di Castri 2003; Scheyvens 1999). One of the examples provided that may help to build community cohesion is some of the work through the local council that is done within neighbourhoods:

Encouraging community cohesion

“People doing jobs where they try to encourage community cohesion, neighbourhood workers employed by the council and they hold events and fun days and music festivals and things like that, free things...where they encourage people to come together and that...improves community wellbeing” (Ava, Health)

Study findings revealed how engaging with the concept of community may help to facilitate synergies between wellbeing, public health and tourism in turn serving as a possible facilitative boundary object that may better enable knowledge sharing.

9.5 Sharing knowledge across council

Mapping the links

Finding parallel interests

Study participants recognised the potential means for knowledge share between public health and all of the services across the council. Conversations with all interview participants underscored the importance of recognising health and wellbeing links across all of the service directorates. From Ethan’s (Public Health) perspective, this type of knowledge share could be possible through a mapping exercise:

“Mapping the links between public health outcomes and public health issues and existing service directorates and plans.” (Ethan)

This evidence highlights the potential for synergies when all of the health links are mapped across the organisation, and then there may be avenues for knowledge sharing at these points of intersection.

Embedding wellbeing across directorates

Within each of the interviews conducted there were phrases used and situations shared, which revealed that the goals and language of the public health team seemed to have trickled into the language and mandates across the whole of the organisation. In the case of councillors and cabinet members there seemed to be a shared interest in considering health and wellbeing impacts. Lucy (Public Health) shares an idea that had recently been tabled:

“It was brought to the table that perhaps it would be a very good idea if every single project that the council embarks upon should consider the impact that it will have on the health and wellbeing of its residents” (Lucy)

Findings drawn from the interview with Lucy highlights how the goal of developing council as a wellbeing organisation may be close to being realised within council directorates. The boundary object of wellbeing within this context holds the potential to create common ground for communication which may lead to local understandings being better contextualised. The similarity of the language used across council would seem to indicate that common ground for communication was slowly being locally embedded across council. Bechky (2003) notes that this is a precondition for the transformation of understanding which is suggested to be necessary for knowledge to be shared.

Study evidence would also seem to suggest that there is a potential role for knowledge brokers in brokering knowledge between council directorates. In the example that Lucy (Public Health) shared within her interview, service managers may play a role as knowledge brokers in identifying how planned projects and programmes may impact upon the health and wellbeing of residents. Similarly, past research indicates that brokers offer a possible route for epistemically diverse groups to communicate (Wenger 1998; Kimble et al, 2010). Brown and Duguid (1998) define brokers as being members of several communities that are able to effectively make connections between them, coordinating new areas from learning and exchange (Brown and Duguid 1998). It is suggested that the broker’s role is to assist other people to transfer, translate and transform meaning during collaborative activities. In this context of using the boundary object of wellbeing, knowledge brokers have a role to play in explaining how these ambiguous terms are being utilised in order to ideally optimise the communicative benefits (Brand and Jax 2007).

Knowledge repositories

Providing useful information

Participants both from public health and tourism departments recognised the potential role of ‘The Academy’ in aligning interests. The Academy is a recently created organisation that is funded by central government, the local council and [Town] university with the main aim of developing coastal tourism through building capacity of businesses to provide an optimal experience for visitors. The Academy captures examples of best practice within their knowledge repository in order to support the dissemination of knowledge to other coastal destinations in the UK.

One of the main remits of The Academy is to provide a research hub to capture some of the best ideas being developed within coastal environments and share it with other

councils, organisations, researchers, and stakeholders. Ella and Jayden (Tourism) highlight the remit of the Academy:

“The Academy’s remit is to provide information that is useful” (Ella, Tourism)

“if you have one single place that’s known as the repository for all the developments other people can use that and learn from and then you can move on and develop things instead of constantly doing stuff that probably has been done before but, people don’t know about it” (Jayden, Tourism)

Knowledge transferability

One avenue for knowledge sharing may be around working with the health team to develop offers that may enhance the wellbeing of both the locals and the tourists. Now, one of the cautions of sharing information and knowledge after that rests on how its transferability is interpreted.

“I don’t think that you could assume that anything you did here about public health would be easily transferable to other coastal environments, it might be but, it would have to be researched first” (Ella, Tourism)

Working more efficiently

In identifying possible areas for synergy and knowledge share, the recently created ‘academy’ has a remit to build a knowledge repository that would act as a reference hub for stakeholders in coastal environments to share their ideas and experiences. Jayden (Tourism) shares how the creation of the academy has the potential to save the council money through greater efficiency:

“We should have had an [academy] a long time ago...if only because we keep reinventing the wheel and we keep wasting money by doing things that have been done 10, 15, 20 years earlier, nobody’s really captured the information” (Jayden, Tourism)

Reviewed research contends that knowledge within organisations can exist within a range of repository types and includes: individual members, roles and organisational structures; organisational practice and its culture (Walsh and Ungson 1991). It is contended that for change in knowledge to be measured, it must first be captured within each of these repositories. Where Argote and Ingram (2000) suggest that repositories have a dual function in that they change when knowledge transfer occurs. Subsequently, the changes in knowledge repositories become indicators of the success of the knowledge transfer.

Developing a sharp offer

Study findings highlight that participants from both public health and tourism feel that synergies and knowledge share between public health and tourism departments could result in the development of really sharp tourism offer achieved through the sharpening

of services right across council. Ethan (Public Health) puts forward his views about the possible value of public health and wellbeing within council:

Sharpening and scoping services

“So there’s a bottom line in this for council it’s not just about fluffy public health wellbeing actually economically, they could develop a really sharp offer, that I think given their proximity to London would attract in a lot of people with hard cash. Rather than perhaps a more down and heel, traditional hen and stag cheap weekend away.” (Ethan)

Isabella (Public Health) also offers her thoughts about the potential outcomes associated with building synergies between public health and tourism departments and what that potentially looks like:

“So it’s about...sharpening and scoping the services and the offer that the borough council has” (Isabella)

Keeping things moving forward

One of the challenges frequently mentioned by tourism participants was the ongoing quest to re-invent the offer and to constantly stay ahead of the curve. In that vein, Max shares his perceptions of the challenge to constantly innovate the tourism offer:

“It’s trying to think long-term about what we’re going to do rather than just spending our money on maintaining and patching up old stuff keeping it going its thinking, how we develop the offer and keep it moving forwards” (Max, Tourism)

Extant literature makes a distinction in defining knowledge transfer at individual and organisational levels. At the individual level, knowledge transfer refers to how knowledge attained in one situation is then applied to another (Singley and Anderson 1989). At an organisational level, Argote and Ingram (2000) define knowledge transfer as the process by which one group is affected by the experience of another. While it is contended that knowledge transfer at the organisational level also involves transfer at the individual level, the challenge to organisational level transfer is to transcend the complexity at the individual level (Argot and Ingram 2000).

9.6 Conclusion

This chapter addressed the following questions: What strategies were used to synergise public health and tourism communities of practice?; and What were the consequences of these strategies?

In the review of literature there is much evidence that highlights the role of boundary objects in the creation of enhanced strategic outcomes. Similar to the wellbeing vision, seafront strategy, and the engaging with community and sharing knowledge many scholars recognise that boundary objects can act as forums which cross group

boundaries and promote integrative deliberation (Legano and Ingram 2009), the creation of hybrid strategies (Bal et al. 2002); and facilitate knowledge growth (Fox 2011). In looking into the future relevance of the strategies described within this chapter, it is important to consider that objects are not just a given but, are constructions that are fluid and both have histories and life cycles. Within this context, it is proposed that objects may be used, discarded and then reused in different ways that contribute to different work streams (Engeström and Blackler 2005). Hence, where a particular pattern of meanings, objects and ideas combine to facilitate collaboration it has occurred within that particular context and is also transient and is able to generate further change (Bresnan 2010).

This chapter has critically examined the study findings to determine the potential antecedents of knowledge transfer; to address the identified gap in the existing literature organisational knowledge transfer. A greater understanding of the catalysts to council's knowledge transfer may offer insight into: performance improvements (Epple et al. 1996; Galbraith 1990), competitive benefits (Schulz 2001; Gupta and Govindarajan 2000), competitive advantage (Tsai 2001; Zahra 2000) and greater innovation (Nonaka 1994). Chapter 10 will discuss the study's phenomenon as influenced by: the process of change, the role of wellbeing, the context of place and engagement strategies.

10. DISCUSSION AND FINDINGS: FINDING WAYS TO ENGAGE WITH A HEALTHY TOURISM “OFFER”

10.1 Introduction

This chapter seeks to explain the central phenomenon (or core category) in this study and illustrates the connections to the categories and sub-categories in the four preceding findings and discussion chapters. These are: the process of change, the role of wellbeing, the context of place and engagement strategies. Study data includes participant observation and semi-structured interviews with members from public health and tourism departments working with a local authority, in a town on the south coast of England. Participant observation occurred prior to the move of the public health agenda to the local authority between January and September 2012. Sixteen interviews were conducted with local council public health and tourism team members five months after public health moved into the local council, between September and October 2013. To ensure confidentiality, all participants' names have been replaced with self-selected pseudonyms being used throughout this study.

Coding and analysis of interview data drawn from participants from public health and tourism teams with the local authority, lead to the emergence of the study's core category, 'finding ways of engaging with a healthy tourism offer'. Six sub-categories were also drawn from the coding and analysis of the data, namely: identifying new approaches, connecting community members, involving the local population, improving health and wellbeing, considering lifestyles, and rebranding the destination. This chapter is guided by the following questions:

- What strategies were used to synergise public health and tourism communities of practice?
- What theory explains the phenomenon of 'finding ways to engage with a healthy tourism offer'?

In addition, the chapter seeks to address the interconnections between the core category and the other categories identified within the study. These are: the process of change, the role of wellbeing, the context of place and engagement strategies. Defining the connections between these categories and the core category is the method by which the theory can be integrated (Corbin and Strauss 1990). In light of this process, there may appear to be repetition within the chapter as past evidence is being utilised within the chapter to outline the categorical interconnections and facilitate theoretical integration.

The chapter framework is illustrated within Figure 18: Framework for the central phenomenon chapter: finding ways to engage with a healthy tourism offer. This serves as an outline for the chapter illustrating the main categories and subcategories and the

order that they will be discussed. Within the structure of this chapter, category and sub-category names were derived from both in vivo codes and co-constructed themes that emerged from the data. This chapter’s framework for analysis serves as a route to identify salient properties and dimensions, with the ultimate aim of increasing the explanatory power of the theory.

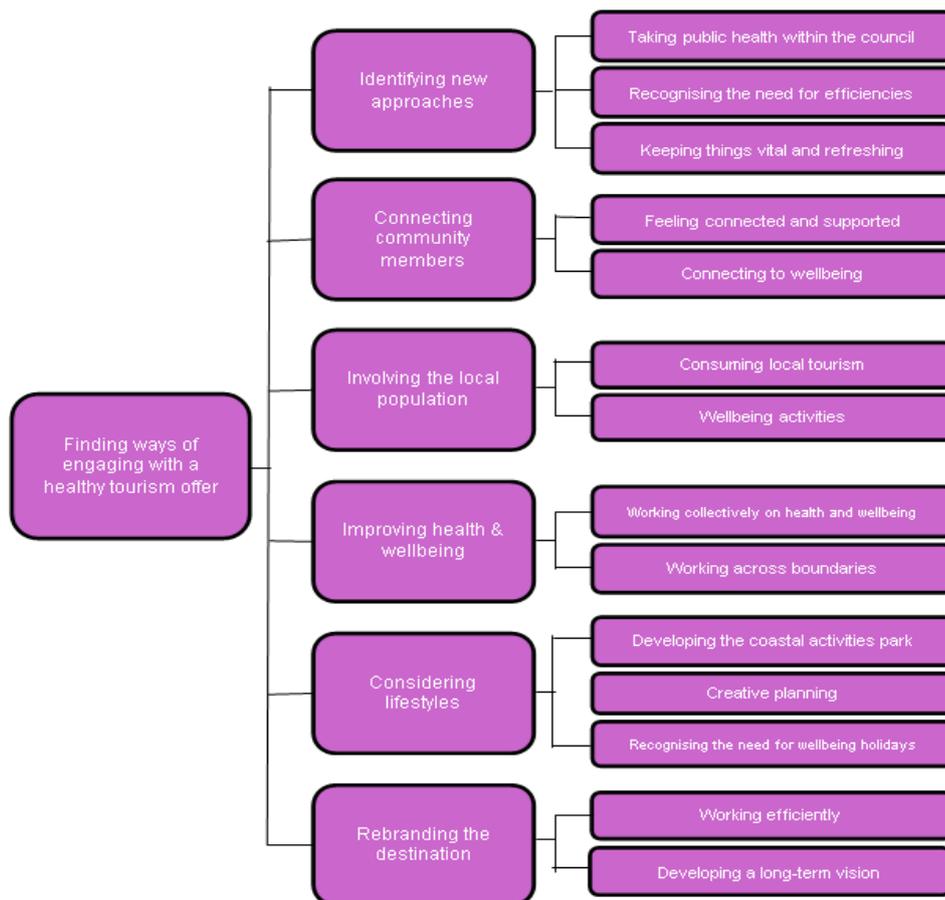


Figure 18: Framework for the central phenomenon chapter: finding ways of engaging with a healthy tourism “offer”

10.2 Identifying new approaches

Taking public health within the council

Working with the health agenda

With the public health agenda recently moving to the local authority at the time that interviews were conducted (2013), there were new interdepartmental forums set up, one of the most relevant to this study is the public health development forum, established to

develop a health and wellbeing framework for council. The first phase of this work focused on mapping the links between public health outcomes and public health issues across the existing service directorates and plans. Max, a member of the tourism team, describes his experience with the public health development forum to date:

“I think they are fairly new on that, as we’ve only just taken public health within the council. I have only attended a couple of meetings so far, my presentations have all been about, this is where we are at, this is our stall, this is our strategy, there’s an opportunity to work with you guys around the health agenda, across the council...so come on let’s start that dialogue.” (Max, Tourism)

Max, who is involved with the development of the seafront strategy, shares how he is approaching public health now being within local council. Interview findings revealed that Max quickly identified the opportunities for synergies between wellbeing, the public health agenda, and the tourism department’s seafront strategy. Interview participants with both public health and tourism recognised how working together on developing a healthy seaside strategy could in turn produce a really sharp tourism offer further benefiting tourists and residents alike.

Local authority’s responsibility for healthcare

Jayden with the tourism team shared how he had an interest in helping the town to be a healthier tourism option, even prior to public health moving back into the local authority:

“Because the local authority’s got the responsibility for healthcare generally in the area.....it’s going to come more to the fore. But even before that we were very keen to work at ways that we could help the [town] to become a healthier option and healthier choice.” (Jayden, Tourism)

One of the key words within Jayden’s statement is the word responsibility, he highlights the fact that the local government now has the responsibility for healthcare. This reorganisation and move of public health to local council is outlined in the coalition government’s 2010 white paper *Equity and excellence: liberating the NHS* (Lang and Rayner 2012; McKee et al. 2011; Walsh 2010). This collective responsibility of the council for the health of their residents presents a necessary engagement point for all members of council. In a similar vein, Lucy with the public health team shares a recent conversation that occurred at the health and scrutiny panel meeting underscoring the importance of considering the health and wellbeing of residents in all of council’s decision-making:

“In fact at the health and scrutiny panel meeting..it was brought to the table that perhaps it would be a very good idea if every single project that the council embarks upon should consider the impact that it will have on the health and wellbeing of its residents – because its beginning to be seen that everything we do has an impact on the wellbeing of residents.” (Lucy, Public Health).

In the review of interview data, it was clear that the language used within the public health team was trickling into common parlance within the cabinet and the tourism team. It became evident that the goal of the public health team to make council a health and wellbeing organisation was gaining some momentum as the language used across council was changing, as there were very similar terms being used in consistent contexts across council.

Within the context of Ethan with the public health team and his role with the public health development forum he could be termed a knowledge broker. Where the practice of brokering has been defined by Wenger (1998) to involve the processes of translation, coordination and alignment between viewpoints and involves connecting practices through the facilitation of transactions. It is proposed that knowledge brokers play at least three roles: as knowledge managers, linkage agents, and capacity builders (Oldham and McLean 1997). Within these roles, brokers are involved within activities that include; communication work, mediation work, and identification work. Sverrison (2001) contends that these activities necessitate various tools like organising meeting or forums, developing databases and creating plain language guides (Kramer and Wells 2005). Research further suggests that one of the critical tasks of the broker is to construct a language whereby participants can engage in a form of mutual understanding (Barnett 2003). Ethan's role gleaned from the study data would seem to meet the knowledge broker criteria put forward in extant research reviewed. He engaged with members across directorates, including tourism to provide leadership around the processes of knowledge translation, coordination and alignment.

Scholars suggest that there is an increasing need for boundary crossing and knowledge brokers within our knowledge society which depends upon interdisciplinary working (Fox 2011; Meyers 2010; Rotmans et al. 2003). Researchers further suggest that the process of knowledge brokering is continually growing in importance (Bielak et al. 2008), where it is contended that knowledge brokering is now a common characteristic among professionals (Kakihara and Sorensen 2002). Knowledge brokers are recognised as the people within organisations that enable the creation, sharing and use of knowledge (Sverrison 2001). It is further proposed that brokering represents more than just moving knowledge it is also viewed as a process which transforms knowledge (Meyers 2010).

Community of practice literature often places brokers at the periphery of the two or more worlds that they are attempting to connect (Wenger 1998), often focusing on the costs associated with brokers marginality in multiple worlds (Star 1991). However, within this study the most likely candidates for taking on roles as knowledge brokers tend to be in leadership roles within each of the communities of practice studied. Lave and Wenger (1991) contend that there are more or less engaged and inclusive ways of being located

in the brokering process, findings from this study offer an example of successful brokering within leadership roles in both communities of practice studied.

Recognising the need for efficiencies

Confronting funding issues/ taking more risks

Interviews with members of the public health team revealed the recurring theme of a greater need for efficiencies, Ethan shares, how from his view, austerity has influenced ways of working within the public service:

“The whole austerity has probably been no bad thing, if I am being honest because I think its forced people to wake up a bit and be a bit more creative, take a few more risks. And actually being a bit more uncomfortable about the funding position is no bad place to be because it forces people to deal with the issues that they needed to deal with before but, were never dealt with before because there was always enough money in the system for the status quo to continue”
(Ethan)

From Ethan’s perspective there is a causal link between austerity and creativity, where he views times of financial crisis to be positive as it does not allow status quo to continue and forces people to deal with the salient issues, mainly around efficient working. Similarly, past literature has defined boundary objects as entities that can improve the capability of an idea, theory or practice to translate across boundaries between communities of knowledge or practice (Wenger 1998; Brown and Duguid 1991). In this definition, one of the very basic benefits of employing boundary objects ‘improving the capability of an idea or practice’ is identified. Additionally, boundary objects have been associated with: enhanced decision making (Spee and Jarzabkowski 2009; Sismondo 1999; Morgan and Morrison 1999); understanding (Williams and Wake 2007; Feldman et al. 2006; Lyytinen et al. 2001; Henderson 1991); coordination and building strategic outcomes (Wilson and Hendl 2007; Fox 2011). Applied to the context in this study of local government working across communities of practice, all of these benefits could enhance the planning and delivery of health, wellbeing and tourism service provisions.

Scope for improving efficiencies

From a different perspective, Isabella identifies a recognised need for efficiencies that became evident through the changes to the remit of public health after the move of the public health agenda to the local authority.

“Because some of these contracts weren’t held by us, they were held by the PCT. So it’s to understand some of the new stuff about that. It’s to identify opportunities to achieve improved effectiveness of the services that we commission, to improve efficiencies, a huge scope for that.” (Isabella)

Participants from the public health team echo the findings from cabinet members and tourism employees, to optimise efficiencies. This mutual interest in fiscal responsibility

presents a potential catalyst for synergies to occur between the construct of wellbeing, public health and tourism, which would ultimately be supported by cabinet members who all have a legal responsibility for the public health of the town. Past literature has highlighted that boundary objects have the potential to bridge both perceptual and practical difference among communities (Lyytinen et al. 2001) further offering the potential to draw on different ways of knowing to enhance common understanding (Brugnach and Ingram 2012). Working to achieve greater efficiencies, may serve as the mutual goal that may catalyse the operationalisation of wellbeing manifested in collaboration between the public health and tourism teams.

Keeping things vital and refreshing

Need for rebranding

Interview participants from tourism and public health both recognised that it is vital to be able to constantly adapt to change. Logan with the tourism team shares his thoughts about the importance of reinvention:

“I think that there is a need to completely reinvent yourself periodically, a bit like pop stars. You take people like Madonna – she completely reinvents herself every decade and is still around...and, I think tourism and tourism wellbeing is something like that. If you use the same name all the way through it loses its impact it loses its appeal. Language changes, perceptions change and I think that you need to tune in to both of those things, language and perceptions to reinvent and catch the trend of the day. So ..I think that there is a need to rebrand and to keep things vital and refreshing.” (Logan, Tourism)

Within the interview conversation with Logan he underscored the importance of an ongoing need to rebrand to catch the trend of the day. In the case of using the concept of wellbeing in the marketing plan to brand the town's tourism offer, Logan associated the concept of wellbeing with health trends, where the concept will need to change and be reinvented over time to stay current. Other study participants from the tourism team while supporting the growing need for a healthy tourism offer, also recognised the potential transience of the word 'wellbeing'.

Resetting the slate

From a public health perspective, Ethan speaks about the impacts of organisational change and how it has the potential to have a positive effect:

“Maybe following a big change, people psychologically maybe are a bit fresher..it's been quite challenging, it's been quite refreshing. It's been a chance to reset the slate a bit and doing things a little bit differently, which is no bad thing...actually maybe that's having a bit of a positive effect on people's mood in the public services because now there's a bit of a challenge to fight for, there's something to do.” (Ethan)

Ethan, has a very positive outlook about how change within an organisation can unlock latent potential. As a caveat, it is worth noting that all of the participants that were interviewed for this study had been appointed to posts after the move of public health to the local authority, which may have an influence on how they perceive the move.

Within the context of local government as an organisation, change will be an ongoing reality, where staff restructures and budget reprioritising will be an ongoing concern. Public health's current position within local government will invariably experience changes in structure and budget allocation which may present opportunities to approach work tasks from a renewed position. It is noted that within public health alone reorganisation has been frequent, with no less than fifteen identifiable major structural changes in the last three decades, which is approximately one every couple of years (Walshe 2010). Similarly, the tourism department will experience these changes within the organisation. From this perspective, both teams will be looking at how they may be able to optimise efficiency and innovation, further, providing a catalyst for interdepartmental collaboration and finding new ways of working together. Additionally, as tourism is one of the main economic drivers within this seaside town, creativity will be needed to reinvent and rebrand the town. That said, the health and wellbeing agenda may offer an opportunity for tourism and public health communities of practice to work together to develop a healthy wellbeing tourism offer.

Connecting core category to the process of change

The category of identifying new approaches, is linked to the findings and discussion chapter entitled *the process of change*. Within this study the process of change category is connected to the central phenomenon or core category as it can be viewed as a causal condition to finding ways of engaging with a healthy tourism offer. The specific point of intersection of the subcategories is at the process of change sub-category of *identifying opportunities for positive outcomes* and the core sub-category of identifying new approaches.

Identifying new approaches – Identifying opportunities for positive outcomes

Evidence examining the process of change category focused specifically on the change when the public health team was both anticipating and newly experiencing the public health agenda moving from primary care trusts to the local authority. Participants from both public health and tourism teams shared their views about the value of change. Tourism participants, linked the ongoing need to rebrand and remarket the tourism destination. From this perspective, change was a necessary part of destination marketing and management where brands would need to change in time to reflect changes in society and market demands. Public health team members, Ethan in particular,

recognised change as a time to deal with some of the existing fiscal challenges through innovative approaches. This recognised need for greater efficiencies presented opportunities for engagement with other directorates to find ways of scoping and sharpening existing services with a public health focus.

During the process of change, study findings revealed how participants perceived the move of the public health agenda to be an opportunity to engage in collaborations focused on building a healthier tourism offer. Tourism participants made reference to the council's Seafront Strategy as being a potential point of engagement with the public health team, with the aim of developing a sharper offer for tourists and residents. Public health respondents, shared how the process of change seemed to reveal how every project that council embarks on is ultimately involves the wellbeing of residents.

In the examination of the process of change experienced both by public health and tourism teams, participants shared how change had the ability to have a positive influence on approaches and perspectives. In reference to the change that occurred with the shift of the public health agenda into local government in April 2013, there was a general acknowledgement that change could have a positive impact on public health teams, tourism teams and council proper. For public health participants change presented an opportunity to engage with departments across council to map the existing and potential connections to wellbeing in the public health agenda. Participants from the tourism team viewed the move as means to have a greater impact on local health through the development of a local tourism plan that integrates health and wellbeing infrastructure, activities and events. The process of change was identified by participants as a means to identify new approaches through engagement with other communities of practice across council.

Organisational change is a process that represents a transition from a current to a desired state (Nadler and Tuchman 1996). Extant literature suggests that change is enabled through creativity, innovation, and initiative where creativity is connected with idea generation, innovation and implementation (Rank et al. 2004). In this context, innovation necessitates transformation of work roles as well as the implementation of new ideas within work teams (Wes and Anderson 1996). Past literature examining the determinants of successful change suggests that positive change behaviour is possible but involves comprehensive approaches at different levels that target specific settings and groups (Grol and Grimshaw 2003). Findings from this study are supported by past organisational change literature in terms of how change can facilitate creativity and innovation. Literature additionally notes how specific approaches are necessary for positive change behaviour to occur and thus could be viewed as recommendations for service managers within the context of this study.

10.3 Connecting community members

Feeling supported and connected

Building a network of support

When interview participants were asked to share their personal thoughts about the concept of wellbeing, some of the most important elements noted were types of social interaction and social connection. Jacob with the public health team connected the notion of feeling supported with greater levels of wellbeing:

“But, also how you feel supported by the people around you so there’s a network around you as well...wherever your peer support is..for me personally that’s what it’s all about” (Jacob)

Jacob underscores the importance of having a network of peer support which he felt was integral to an individual’s and a society’s wellbeing. Past research has also highlighted how peer support is connected to improved levels of wellbeing (Flaspohler et al. 2009; Van Ryzin et al. 2009). Similarly, Isabella (Public Health) when asked about what underpinned societal wellbeing mentioned close networks:

“It’s about social connectedness, close networks you have with friends and family” (Isabella)

Study participants talked about social connection and interaction as underpinning wellbeing for the individual and for society. Reviewed literature defines social connectedness as a person’s subjective awareness of being in a close relationship with the social world (Lee and Robbins 1995). Additionally, a lack of social connection has been associated with loneliness and isolation (Baumister and Leary 1995; Kohut 1984). Daniel with the public health team, suggests how interventions focused on connecting people may be of interest to officers within the local authority:

“there’s a lot of interest by local authority officers because of the social care side...about how to connect people in who might have a sense of loneliness and some people who it can be very difficult to engage” (Daniel).

Findings drawn from the interview with Daniel indicates that there are potential areas of synergy across council with the development of interventions that focus on social connections. Past literature also indicates that there is a link between social connectedness and greater levels of wellbeing (Jose et al. 2012; Lee and Robbins 1995). One of the leading challenges to wellbeing within the town was noted among participants to be loneliness which is linked to depression, poor quality of life and chronic conditions, further emphasizing the need for social connection. Programmes developed between public health and tourism provides an opportunity to build interventions focused on promoting greater social connections. Health promotion programmes could increase

strategies to engage members of the community that are at risk of suffering from loneliness and be included within the seafront strategy.

Feeling better helping someone else

Evie (Public Health) shares another aspect of social interaction that she perceives to be linked to wellbeing:

“I think it’s a very basic premise that you feel better if you are helping someone else or taking part in community projects, it gives you a feeling of wellbeing.”
(Evie)

Social interaction and connection were revealed to add value to people’s lives and be strongly connected to levels of wellbeing. Study findings are theoretically underpinned by the Aristollian concept of eudaimonic wellbeing which describes how humans are able to find meaning and fulfill their true potential through collective and social relationships (Aristotle 1952). Currently, eudaimonia is conceptualised as an overarching term which includes psychological wellbeing, virtue/excellence, intrinsic motivation/authenticity, flow, fully functioning, meaning and purpose, and a concern for others (Wong 2011). Where eudaimonic living can be characterised by motivations which includes the pursuit of intrinsic goals and values like personal growth, relationships, community and health rather than extrinsically motivated goals and values like wealth, fame, image and power (Ryan et al. 2008).

There are several beneficial outcomes that have been linked to eudaimonic living, where people with high levels of eudaimonic living more often behave in more prosocial ways (Waterman 1981), further benefiting the collective at family and societal levels (Ryan et al. 2006). Eudaimonic pursuits have also been linked to a more lasting subjective wellbeing and a higher baseline level of wellbeing. Eudaimonic living has also been associated with greater physical health (Ryff and Singer 2006; Williams et al. 1998).

Connecting to wellbeing

Coming together to achieve something

Ella, with the tourism team, uses the example of exercise as being an area that wellbeing could connect public health and tourism departments locally.

In exploring ways that wellbeing, public health and tourism may connect she discusses the possible role of exercise in promoting social interaction:

“Interacting with people...experiencing parts of the culture..it can be a whole portfolio of ways to make your life feel better... exercise for example, cuts across the social interaction of people coming together to achieve something” (Ella)

In the course of the interview, Ella cited the newly developed marathon event as an example of how people socially connect to achieve a goal. The example of participation

in a marathon represents an example of a serious leisure activity (refer to Chapter 2, p.35) which is defined as an activity that requires special skills and knowledge and may not be entirely pleasurable at times and could involve embarrassment or danger (Stebbins 2008; 1997). Serious leisure has been associated with a host of personal rewards including: fulfilling one's human potential, expressing one's skills and knowledge, having cherished experiences and developing a valued identity (Stebbins 2001). There are additional social rewards associated with participation in serious leisure that include: meeting people, making friends, and taking part in a group. Within serious leisure activities, participants describe their involvement as being both satisfying and rewarding (Stebbins 1997) and can be theoretically aligned with eudaimonic wellbeing (Voigt et al. 2010). From a wellbeing perspective this is significant as 35% of a person's happiness can be determined by intentional activity (Lyubomirsky et al. 2005), which is a relevant context to tourism (Voigt et al. 2010).

Connecting wellbeing to community cohesion

Another variation of social connection as it may connect wellbeing, public health and tourism is around the notion of community cohesion. Ava shares her views about the importance of people within the town feeling connected to their community:

"Then I think there is a strong link between community cohesion and people's wellbeing because people need to feel connected in their community" (Ava, Public Health)

Past research emphasises the significance of social interaction in public spaces, where it is noted to provide respite from daily routines, sustenance for residents' sense of community, and opportunities for sustained bonding relationships or networks (Cattell et al. 2008). In the context of the direction coming from UK's central government, to date, there are various initiatives which focus on nurturing social inclusion and community cohesion as a strategic consideration in the role of public space (Office of the Deputy Prime Minister (ODPM 2003; 2002).

The concept of social wellbeing is underpinned by positive psychology which focuses on feeling good ourselves and in our social relationships, with families and peers and in our communities (Keyes 2002). Similarly Layard (2005) promotes a concept of wellbeing that emphasises our social being. Increased social connections have been related to promoting health and wellbeing through providing support, developing a sense of identity and belonging and enabling social integration (Blaxter 1990; Wellman and Wortley 1990; Brown and Harris 1978). Wellbeing theories, underscore the benefits associated with promoting social connections and may co-locate public health and tourism strategies. Community-led approaches are increasingly effective strategies employed to target health improvement (Roussos and Fawcett 2000). That said, a community-led approach

to health improvement may offer an approach that could empower community members to actively guide the actions that impact their own health. Additionally, tourism development planning could benefit from this approach as resident involvement could improve the destination and simultaneously improve resident wellbeing through meaningful social connection. Literature reviewed suggest that the tourism industry plays an important role in enhancing societal wellbeing and improving quality of life (Chen et al. 2006) and ultimately creating healthier communities (Munthe 2008). Past research has also contended that local tourism debates often reflect sustainability, community wellbeing and social cohesion (Beeton 2006; Murphy and Murphy 2004).

Connecting the core category to the role of wellbeing

The concept of **connecting community members** is linked to the category, the role of wellbeing, specifically at the intersection with the subcategories of connecting to societal wellbeing, and levers to promoting wellbeing. The role of wellbeing, within this study, can be viewed as an intervening condition in the process of finding ways to engage with a healthy tourism offer, the central phenomenon of the study.

Connecting community members - Connecting to societal wellbeing

Study findings highlighted how participants connected achieving greater levels of societal wellbeing with social connectedness, a sense of community and doing things for others. Where past research has emphasised the links between social connectedness and the maintenance of health and wellbeing (Cohen et al. 2004; Anderson 1992; and Fawzy et al. 1990), further highlighting how shortfalls in social support have been connected with adverse health outcomes in elderly populations (Reblin and Uchino 2008; Uchino 2006;) which includes physical health and depression (Dennis et al. 2005). Within the context of this study, it is a seaside destination which has a higher elderly population than other locations in the UK (Cave 2010). That said, it has been suggested that interventions targeting social connectedness and the elderly may yield a high social return on investment (Lingane and Olsen 2004). Another emergent theme in the study findings highlighted the role that helping others played in individual and societal wellbeing. Past literature identified that volunteering may offer an example of an intervention that may positively affect individuals' wellbeing through the intrinsic motivation to care about others' welfare (Menchik and Weisbrod 1987).

The sub-category, connecting to societal wellbeing is linked to the core category of finding ways to engage with a healthy tourism offer through the theoretical construct of eudaimonic wellbeing, where public health and tourism departments may improve resident wellbeing through the development of greater eudaimonic activity and events offers. Research suggests that eudaimonic wellbeing can be conceptualised as a term

that encompasses psychological wellbeing, virtue and excellence, intrinsic motivation/authenticity, flow/fully functioning, meaning/purpose, and concern for others (Wong 2011; Kashdan et al. 2008; Ryan et al. 2008; Waterman 2007; Seligman 2002; and Ryff 1989). Participants in this study linked societal wellbeing with concepts associated with the theoretical construct of eudaimonic wellbeing. Thus, the connection between the core category and role of wellbeing in this instance is around the notion that connecting community members will ultimately improve levels of the eudaimonic type of wellbeing. In turn eudaimonic approaches can offer a means for public health and tourism team members to engage with a healthy tourism offer and achieve greater levels of wellbeing that has more longevity for the local population.

Connecting community members – Levers to promoting wellbeing

Levers to promoting wellbeing, a sub-category of the role of wellbeing, highlights the importance of social interaction and community cohesion in the promotion of greater levels of health and wellbeing. Past literature advises that across the lifespan, individuals who are embedded within a social network have a greater level of wellbeing than those individuals who are socially isolated (Fioto 2002; Machielse 2000). Linked to the tourism agenda, scholars suggest that different forms of leisure can contribute to the development of social capital (Jarvie 2003; Hemingway 1999). Past studies have highlighted how the social value approach, which measures the economic return on investment of community development found that an investment of £233,500 into community-development finds a return of £3.5 million in social return which represents a return of 15:1 (Thome and Fisher 2013). In terms of identifying priority investments, Lomas (1998) contends that facilitating social networks has a comparable impact to that of medical interventions, where he further suggests that for every 1000 people introduced to an intervention each year social cohesion could prevent 2.9 million heart attacks. Additionally, an example of developing social capital among elderly populations is in the UK's recently developed friendship clubs. A recent study proposed that the basis for the success of the clubs was their organisation which enabled older aged populations to engage, develop friendships and support networks (Hemingway and Jack 2013).

The role of a wellbeing sub-category of levers to promoting wellbeing, is linked to the core sub-category of **connecting community members** through eudaimonic theories which highlight the important role of social connectedness in raising levels of wellbeing. Eudaimonic living has been associated with outcomes that include, life meaning (Huta and Ryan 2006; McGregor and Little 1998), subjective vitality (Ryan and Frederick 1997), and physical health (Ryff and Singer 2006; Williams et al. 1998). Increasingly, research asserts that the promotion of eudaimonic behaviours and lifestyles, improves society as a whole, where members demonstrate greater care, concern, and responsibility for their

actions (Ryan et al. 2006; McHoskey 1999). The self-determination theory (SDT), a eudaimonic theory, suggests that wellbeing is achieved through the satisfaction of psychological needs for relatedness, autonomy and competence (Deci and Ryan 2000). Where it is further proposed that if these needs are satisfied, it will allow people to flourish and if they remain unsatisfied, wellbeing will be compromised (Deci and Ryan 2000). Practical examples, underpinned by eudaimonic wellbeing show the connections between the intervening role of wellbeing and the study's central phenomenon and how public health and tourism departments can find ways to engage with a healthy tourism offer.

10.4 Involving the local population

Consuming local tourism

Living in a tourism destination

One of the themes that emerged from the data derived from study participants with the tourism department is the role that residents play in local destination tourism. Interview data revealed that tourism participants often emphasised how lucky the local population are to live in such a beautiful destination, how lucky they are to have such a spectacular natural resource where there live. This data was set against the backdrop of a well-known tension between residents and tourists within the town due largely to the volume of tourists to the area during peak seasons.

Jayden, a member of the tourism team describes how the business of tourism is visible within a destination, as opposed to a business akin to a factory, where the destination can be enjoyed by the residents:

"I think that's the nice thing about being a tourism destination, is that you've got a service that local people consume themselves, they can enjoy themselves..and that can make them feel good about it" (Jayden)

There has been much research which further developed past models (Irridex model, Rothman's model) of resident attitudes towards the social impacts of tourism at the destination level (Williams and Lawson 2001; Smith and Krannich 1998; and Davis et al. 1988). Davis and colleagues (1988) segment residents into five categories: *tourism haters*, who have negative opinions about both tourists and tourism; *lovers*, who have an extremely favorable opinion; *cautious romantics*, who acknowledge the benefits of tourism but have anti-growth beliefs; *in-betweeners*, who have reasonable opinions about the benefits of tourism and the continued growth of tourism; and those *that love em for a reason*, who approve of tourism based on the link to job creation and recreation opportunities it affords residents. There are thus, a range of resident opinions about the local tourism industry which could in turn have an impact on their levels of wellbeing.

Max, another member of the tourism team shares his first-hand experience of living in the town:

"And also to benefit local residents as well because obviously this is a fantastic natural resource that we have, we are very lucky" (Max, Tourism)

In this example, Max could be within the 'love em for a reason' segment of residents as his job exists largely because of the local tourism industry and living in the area also affords him the opportunity to enjoy recreation activities by the seaside. Interview data gleaned from Max's interview further revealed that he was also not originally from the area but, came here to change the pace of life from where he and his family were living before. That said, his view of place may be influenced by the fact that he was not originally brought up in the area.

Lucky to have that offer all year round

Ella, with the tourism team shares her opinions about how residents may feel about the town as a tourism destination.

"And I think sometimes residents forget that not many places in the country have that..as a matter of course and they are very lucky to have that kind of offer all year round. So yes, I think my feeling is that [the town] is a very good place to be born and grow up" (Ella)

In this context, Ella was discussing how she viewed the wellbeing amongst members of this town, or as a society, and in her view it was a good place to be and would positively affect a person's wellbeing. She would also seem to be segmented as a *love em for a reason* resident as she would support the role of tourism creating jobs, as hers was newly created through tourism partnerships and spoke about festivals on the seaside that she enjoyed with members of her family.

Wellbeing activities

Getting the offer right for residents and tourists

In the interview with Max from the tourism team, he shares an interesting finding from the recent *Seafront visitor survey 2013*:

"Our guaranteed seafront users year round it's the residents and even in the height of the summer..nearly 60% of our beaches is our residents, so if you get the offer right for the residents, then the tourism offer sort of follows behind" (Max, Tourism)

During the interview with Max, he shared this survey finding with more than a hint of surprise as there is an inclination to believe that mass tourism at the main beach displaces residents from the area. The acknowledgement that there are a higher percentage of residents than tourists during peak seasons provides evidence to support

the need for tourism planning along the seafront to include directorates like public health that are focused on the wellbeing of residents.

Local participation in wellbeing activities

From a similar perspective, Logan from the tourism team shares his thoughts about how the recreation destination may provide wellbeing activities for residents:

"Because it is a destination, it's by the sea, it is a recreational destination, they probably have a lot of wellbeing activities..if you look at the usage of the beach, it tends to be lots of local people that do it, it's not just people coming in" (Logan)

One of the main questions in the tension that seems to exist between residents and tourists, is whether destination tourism contributes to the wellbeing of the local population. Looking forwards to the implementation of future phases of the seafront strategy, there is ample evidence to support collaboration between public health and tourism directorates through the concept of wellbeing.

Connecting the core category to the context of place

Involving the local population – Healthy offer for locals and tourists

The core sub-category of involving the local population is connected to the context of place sub-category of a healthy offer for locals and tourists as there is a link between the local population and synergies between public health and tourism departments creating a wellbeing infused tourism offer. Study findings around the category of a healthy offer for locals and tourists, highlights how tourism employees with the local government feel that locals are lucky to live by the seaside and experience the associated benefits. Social exchange theory has been of interest to tourism researchers as the theory is underpinned by the assumption that tourism development is accompanied by economic benefits in exchange for social and environmental impacts (Hammil 2004) The social exchange theory suggests that locals are more likely to participate in an exchange when they perceive that they will experience benefits without suffering any undesirable costs (Allen et al. 1993). Applied to involving locals in the planning of the seafront strategy, for example, locals may participate in engagement events around tourism planning if they perceived they would benefit from the experience. In turn involvement of locals in planning could address the public health agenda around health promotion and be a forum for public health and tourism departments to co-locate work agendas around wellbeing and engaging with a healthy tourism offer. This social exchange may also present the opportunity to determine how tourism events and activities impact local levels of wellbeing, which could also meet public health agenda targets. This social exchange might provide an opportunity to further sharpen the local tourism offer and bridge any tensions between residents and destination development.

Study findings also revealed how the local population were the main users of the main beach during the peak summer season which is an important consideration as recreation and tourism have been identified as agents of change in landscape development (Palang et al. 2005; van der Vaart 2003; Butler et al. 1998). Kanika and colleagues (2006) further propose that the place relations of the residents and their needs are important to development, as are the place relations of the tourists. It might be worthwhile to better understand the expectations of locals and tourists and determine parallel themes in the development of the seaside resort. Involving the local population, presents an opportunity for public health and tourism teams within the local authority to understand place relations as they shape resident and tourists' expectations and the demand for health and wellbeing activities and events within tourism strategies.

10.5 Improving health and wellbeing

Working collectively on health and wellbeing

The town's wellbeing vision

When the data for this study was being collected, the council in general were coming to terms with the overall collective vision for wellbeing. The move of the public health agenda into the local authority seemed to promote greater discourse focused on health and wellbeing across council. Ava with the public health team outlines the process of wellbeing being developed into the town's vision:

"It's sort of an overall vision for the town. Where hopefully we all work together collectively as a town to work on the kind of key issues affecting the town at the moment." (Ava, public health)

Within this study example, wellbeing is viewed as a concept that may act as a boundary object that acts as a bridge to communication between the public health and tourism communities of practice within the local authority. Star and Griesemer (1989, p.393), originally defined a boundary object as:

Objects that are both plastic enough to adapt to local needs and the constraints of the several parties employing them, yet robust enough to maintain a common identity across sites. They are weakly structured in common use, and become strongly structured in individual-site use. These objects may be abstract or concrete

More recently, Harvey and Chrisman (1998) claim that boundary objects facilitate a shared understanding through the moderation of differences further allowing agreement along ontological and epistemological boundaries in turn creating things that have greater validity to a larger portion of society. Huvila (2011) describes boundary objects as being mechanisms of translation, where they are central to developing coherence across different communities. Bechky (2003) suggests that these objects are capable of

both promoting and suppressing knowledge sharing across boundaries. Applied to this study, Carlile (2002) proposes that these objects may play a coordinating role facilitating action, this so called syntactic coordination represents the process of information transfer. Thus, past research supports the potential for the wellbeing construct to bridge communication and information transfer between departments.

Opportunities to improve health and wellbeing

Ethan with the public health team recalls a recent event that illustrates the potential for synergies between public health and tourism communities of practice:

“At the last meeting we had a presentation with one of the seafront strategy team...who’s been involved in developing the seafront strategy... which was really good because I think he spotted straight away the potential for the development of the seafront strategy to incorporate opportunities to improve health and wellbeing.” (Ethan, Public Health)

In this example, Ethan provides an example of how wellbeing may be meaningfully integrated into the work of public health and tourism team members. Similarly within the literature two of the prominent features noted among boundary objects is that they have interpretive scope and flexibility, where they are meaningfully and usefully integrated into the work tasks of workers from diverse fields (Spee and Jarzabkowski 2009; Star and Griesemer 1989). It is contended that a boundary object’s flexibility is fundamental to the process of communication between different groups or communities of practice (Sapseed and Salter 2004; Henderson 1991).

Working across boundaries

Structuring portfolios to have blurred boundaries

In terms of the way in which cabinet structure was set up, it was deliberately designed with boundaries between portfolios being blurry in order to ‘force’ members to work together on some of their projects and tasks. Joshua, with the tourism team outlines his plan in designing the portfolio structure:

“when I set up this structure I did it so there are areas where they are not totally defined edges to portfolios which forces two or three portfolio holders to work together on some things” (Joshua)

Past literature suggests that workings across boundaries between disciplines, is where innovation is proposed to happen (Kimble et al. 2010; Fagerberg et al. 2005; Leonard-Barton 1995). Whilst past studies have identified boundaries as markers of difference, this study is guided by the definition of boundaries viewed as an interface that may facilitate knowledge production (Akkerman and Bakker 2011; Star 2010; Lamont and

Molnár 2002). Within this study, an important consideration is the types of boundaries that need to be crossed to ascertain the potential level of complexity. Carlile (2004; 2002) proposes that there are three types of knowledge boundaries: syntactic, semantic, and pragmatic, each with an ascending level of associated difficulty. *Syntactic* boundaries are viewed as being the simplest as there is an assumption that knowledge is transferred between actors that share a common syntax. Semantic boundaries are suggested to be more complex as common meanings are still being developed to translate knowledge. Pragmatic boundaries are contended to have the greatest social and political complexity as mutual interests still need to be developed in order to 'transform' knowledge (Carlile 2004). Within the context of this study, boundaries that need to be crossed between directorates or communities of practice could be termed pragmatic as there is not necessarily a mutual interest in the operationalisation of the wellbeing construct.

To better understand the potential and benefits of knowledge transfer, Carlile and Robertisch (2003) developed a framework to understand boundaries which outlines the three properties of knowledge at a boundary: difference, dependence and novelty. Within this framework, difference refers to both the amount and type of diversified knowledge that is required to create innovation. Knowledge, in this context, is understood as an investment which require time and resources to acquire thus, there are costs associated with both giving it up and obtaining new and different knowledge (Carlile 2002). Dependence is the next relational property of knowledge, which is defined as the conditions where two units must consider each other in order to meet their goals (Litwak and Hilton 1962). The third relational property of knowledge at the boundary is connected to how novel situations appear (Carlile 2002).

Within this study, the relational property of *difference* refers to amount of knowledge (type of knowledge tacit or) held by the public health and tourism communities of practice, which includes affiliated cabinet members and councillors. Data gleaned from interviews with participants in this study reveal that there are quite disparate beliefs and interests held between members of each of these teams. Public health team members are primarily interested in health promotion/prevention and members of the tourism team focused mainly on ways to promote the town as a tourism destination. This disparity in interests between the two communities of practice would suggest that there is potentially, a large amount of specialised knowledge present at the pragmatic boundary between directorates. *Dependence*, the next relational property of knowledge is evident in the excerpt from Joshua's interview where he intentionally created blurred boundaries between portfolio holders to necessitate collaborations. Within this situation, success is only possible when boundaries are crossed thus, each of the cabinet members must consider each other to meet their own goals. The third relational property of knowledge

at the boundary is novelty and in this study there is a large novelty factor involved twofold as the public health agenda has just entered the local authority and the concept of wellbeing is relatively new where working definitions were to date, nebulous. That said, during 2013-2014 the property of novelty would be present and thus, the capacity of knowledge and the ability of the actors to use it would become salient (Carlile 2002). These relational properties contribute to the framework to understand learning that occurs at the boundaries (Akkerman and Bakker 2011; Lave and Wenger 1991). Research proposes that there are four possible learning mechanisms that can occur at the boundaries: identification, coordination, reflection and transformation (Lave and Wenger 1991).

Public health integration

Within the five months that public health had been within the local authority, members of council were beginning to give greater consideration to health and wellbeing within their work remit. Mia with the public health team, shares her observations:

“Public health is all encompassing and so it runs through every single directorate in the local authority and wellbeing therefore runs through every single directorate... but, probably quicker than I realised...public health is slowly integrating with all of the directorates” (Mia, Public Health)

Relatedly, past research suggests that the ability to transfer knowledge will improve an organisation's performance (Epple et al. 1996; Galbraith 1990). To clarify, knowledge transfer as defined at the individual level refers to how knowledge attained in one situation applies to another (Singley and Anderson 1989). At the organisational level, knowledge transfer refers to the process by which one group is affected by the experience of another (Singley and Anderson 1989). Research suggests that knowledge transfer has occurred when experiences in one part of an organisation affects another part and can be either implicit or explicit (Argote and Ingram 2000).

Connecting the core category to engagement strategies

Improving health and wellbeing – creating a wellbeing vision

The core sub-category of improving health and wellbeing is connected to the engagement strategies sub-category of creating a wellbeing vision. This connection is fused through the notion of wellbeing as a boundary object that facilitates collaboration. Study findings highlighted how the development of the wellbeing framework within council promoted opportunities for interdepartmental collaboration. The process of building the wellbeing strategy became a way for internal and external stakeholders to engage at semantic and pragmatic knowledge boundaries (Carlile 2004). A semantic boundary is suggested to be a complex knowledge boundary, as common meanings are something that still needs to be developed in order for knowledge to be translated.

Pragmatic knowledge boundaries are recognised as having the greatest social and political complexity where mutual interests still need to be developed in order to transform knowledge (Carlile 2004; 2002).

The public health development forum was set up when the public health agenda moved to the local authority with the aim of engaging directorates across council in framing their current and future work in relation to health and wellbeing outcomes. Within the context of employing the wellbeing construct at the public health and development forum, the forum itself can be viewed as an entity that may improve the capability of an idea, theory or practice and translate across boundaries between communities of knowledge or practice (Wenger 1998; Brown and Duguid 1991). The forum provides an opportunity for discussion that may reveal the need for knowledge exchange (Wilson and Herndl 2007) and also serve as a means to establish a shared language where knowledge and meaning can be shared (Carlile 2002).

Study findings also highlighted how wellbeing could cross portfolio boundaries of tourism and health cabinet members in the town council. Specific evidence from a participant with the tourism team outlines how portfolios were originally set-up with blurry boundaries in order to force two or more portfolio holders to work together on some projects. Past research also supports the idea that boundary objects may promote the transfer, translation and transformation of knowledge across pragmatic boundaries (Carlile 2004). Additional study findings drawn from an interview with a public health team member revealed how increasingly, wellbeing was seen to be a part of work across council directorates. Further to that, all learning is argued to involve boundaries (Akkerman and Bakker 2011), where there are four potential learning mechanisms that can take place at boundaries: identification, coordination, reflection and transformation (Lave and Wenger 1991). The use of the concept of wellbeing in council offers potential learning with the ultimate aim being the transformation of knowledge that produces an innovative outcome that synergises public health and tourism agendas. In this context, transformation refers to changes in practices that occur in light of boundary crossing and may refer to the creation of a new hybrid practice, a boundary practice (Akkerman and Bakker 2011).

The creation of a wellbeing framework within local council has provided an opportunity for greater collaboration, knowledge exchange and knowledge sharing which has every chance of ultimately improving the health and wellbeing at the local level. The learning that occurs at the boundaries between communities of practice promotes the process of knowledge transformation which creates new practices across the service and offers a way to engage with the town's healthy tourism strategy.

10.6 Considering lifestyles

Developing the coastal activities park

Seeing obvious synergies

Interview data revealed that one of the areas that wellbeing may synergise public health and tourism directorates is in the development of the coastal activities park, which is part of council's seafront strategy. Lewis sees obvious connections between the coastal activities park wellbeing, public health and tourism:

"You can see obvious synergies with the coastal park and engaging residents in the value of tourism" (Lewis, Tourism)

In the context of the interview, Lewis is responding to a question about potential areas for wellbeing to promote collaborations between public health and tourism departments. In this example, he views the coastal activity park, part of a tourism strategy, as offering a host of wellbeing activities that can be experienced by the local community and potentially add value to residents' lives. Research suggests that views of the host community that are positive will enhance the tourists' experience and contribute to the destination's attractiveness (Fredline and Faulkner 2000). Thus, there is potential for a symbiotic relationship between the tourism department and local residents; where the destination supports residents' wellbeing the residents' in turn contribute to the success of the tourism destination.

Aligning activities with public health objectives

From a public health perspective, Lucy, describes how she perceives the activities park to be aligned with public health objectives:

"Part of that is going to be the coastal activities park...where those activities are very much aligned with the public health objectives...there's a pilot project about who are at risk of diabetes and getting them to do more exercise and make it fun...I think this is the answer for working together" (Lucy, Public Health)

Increasingly scholars have recognised natural environments as optimal settings for health promotion (DEFRA 2011; Hansen-Ketchum et al. 2011; 2009; Mitchell and Popham 2008). In terms of planning and infrastructure development, extant research suggests that community leaders and public health officials need more information about the types of community design principles that are most effective in improving local physical, mental, and social wellbeing (Dannenburg et al. 2003). Scholars also support the claim that exercise in natural environments can promote psychological wellbeing (Thompson Coon et al., 2011; Bowler et al. 2010). It is further contended that natural environments provide restoration from mental fatigue and stress, positively effecting mood and blood pressure (Barton and Pretty 2010). There is a catalogue of evidence

that supports the connections between exercise in natural environments and greater levels of wellbeing, which would seem to align with the public health agenda to improve population level health. The coastal activity park provides a facilitative boundary object that may further catalyse collaboration between public health and tourism teams.

Creative planning

Finding new ways to engage

The interview data drawn from both public health and tourism team members highlights the recognised need by both teams to find ways to engage people in wellbeing activities. Max from the tourism team describes the planning considerations associated with health and wellbeing activities:

“thinking about wellbeing and health, it’s not just about providing sort of traditional sport or health activities, it’s about finding new ways to engage people that want to be doing something else” (Max)

Within this context finding ways for residents and tourists to engage with wellbeing activities offers a potential area for collaboration between departments. Findings drawn from interviews with both tourism and public health participants indicated that there was a greater interest in promoting health and wellbeing in the development of seafront strategies. One of the noted challenges with both departments was how to engage those who do not want to be engaged. The process of discovering new ways to engage citizens in activities that promote wellbeing may necessitate collaborative working between public health and tourism.

Recognising the need for wellbeing holidays

Being more aware of health and wellbeing

Interview data suggests that within the current societal climate there is an increasing need for activity holidays or wellbeing vacations. Lucy shares her views about the future demand for activity holidays.

“I think ...activity holidays will be the thing of the future because people are being more and more aware of health and wellbeing and the dangers of...not being very active are becoming more widely spread” (Lucy, Public Health)

Study evidence defines the lifestyle concept similar to that of Green and Kreuter (1990), who indicate that it is a consciously chosen personal behaviour of individuals as it relates to health. Similarly, the World Health Organisation (1986) defines health promotion as the process which enables individuals to increase their control and improve their health. One of the challenges noted in the review of literature is the negative way in which lifestyles are framed; in terms of risk factors like smoking or substance abuse which is not health promotion but disease prevention (Antonovsky 1996). Conversely, public

health is currently guided by the salutogenic model of health promotion, which assesses a person's resources that contribute to positive health and wellbeing (Lindstrom and Ericsson 2006).

Carrying greater levels of stress

From another perspective, Logan shares his observations about the growing levels of stress within society and how it may catalyse a greater demand for wellbeing vacations:

“When you’ve had an economic recession like we’ve had over the last four or five years, you find that they reduce costs by adding and spreading workloads and some people pick up huge amounts of work load and carry that...and I think that just builds stress and it works against wellbeing and it probably makes the need for proper wellbeing vacations for most people really important” (Logan, Tourism).

To that end, several researchers postulate that there is a growing concern about wellbeing, that is reflected in both tourism and public health planning agendas (McCabe et al. 2010; Fayers and Machin 2007; Skevington et al. 2004). Recent literature asserts that public planning, tourism and practice are currently moving towards a new paradigm that considers overall societal health that is rooted in the wellbeing of individuals and communities (Anderson et al. 2010; Local Government Improvement and Development 2010). These trends in thinking about tourism and public health offer opportunities for synergy in local development and planning. A new shift in focus recognises wellbeing as central to people's lives thus, there is greater importance placed on enhancing local area strategy and service delivery decisions (Local government improvement and development 2010).

There have been several waves in the development of public health policy, indicating the role of public health within society (Hanlon et al. 2011; Hemingway 2011). The current fifth wave of public health policy highlights the need for the re-evaluation of public health's roles in maintaining and enhancing wellbeing, a eudaimonic approach (Waterman 1993) which is concerned with living well and realising one's true potential (Deci and Ryan 2008). Research also highlights the important role of the tourism industry in enhancing societal wellbeing and ultimately creating healthier communities (Munthe 2008).

Connecting the core category to engagement strategies

Considering lifestyles – Building the seafront strategy

The core category of considering lifestyles is closely aligned with the engagement strategy category of building the seafront strategy. The development of the phased tourism approach to developing the town's seafront reveals examples of wellbeing activities that align with the public health objectives. For example, the coastal activities

park focuses on developing exercise opportunities that are enjoyable. This focus on developing enjoyable exercise is supported by past research which proposes that humans tend to perform as their ancestors did and exercise only when it is fun, a form of play, or is deemed necessary (Lieberman 2015).

The seafront strategy plans to divide the seafront into different zones where zones offer a different range of experiences for the visitors and locals. An example that may provide new opportunities is the planned creation of an elevated walkway which would offer an alternative visual perspective to the seafront and support healthy lifestyle choices. This is an example from the planned natural zone which could encourage greater levels of activity amongst an older demographic. Scholars have similarly indicated that regular exercise is beneficial for older adults; improving the function of their physical wellbeing (Young and Dinan 2005; Taylor et al. 2004; Keysor 2003). Through the provision of a wellbeing tourism offer, this strategy may in turn attract a different type of visitor to the area, diversifying the tourist profile.

In this study, the seafront strategy is cited as a possible boundary object that may catalyse a fusion between the concept of wellbeing, public health and tourism. The consideration of healthier lifestyle options for residents and tourists is embedded within the strategy specifically in plans focused on the coastal activities park and natural zone. Researchers also assert that as people's lives are increasingly dominated by busy and stressful lifestyles, the demand for healthy options increases in both their leisure and holiday time (Keynotes Ltd. 2003; Douglas 2001). This demand for health and wellbeing presents an area for local public health and tourism teams to work together on the development of wellbeing infrastructure, events, activities and interventions that contribute to a healthy tourism offer.

10.7 Rebranding the destination

Working efficiently

Developing a sharp offer

In the consideration of avenues for public health and tourism teams to work collaboratively, Ethan shares his views about the tourism potential within the town and value of public health and wellbeing contributions:

“So there’s a bottom line in this for council it’s not just about fluffy public health wellbeing actually economically, they could develop a really sharp offer, that I think given their proximity to London would attract in a lot of people with hard cash. Rather than perhaps a more down and heel, traditional hen and stag cheap weekend away.” (Ethan, Public Health)

From this perspective, rebranding the destination presents an opportunity to bring health and wellbeing considerations to the forefront in planning processes. Related research contends that in a competitive global marketplace, it is imperative for destinations to create a unique identity to separate themselves from their competitors (Hudson and Ritchie 2009). Experiential marketing is proposed as a branding technique that views consumers as emotional beings and concentrates on attaining pleasurable experiences (Williams 2006). When successful, it is suggested to achieve short-term behaviour change and build an emotional connection and relationship between brand and product (destination) (Robertson 2007). Experiential marketing focuses on the consumers total experience (Leighton 2007) suggesting that experiences may engage visitors' sense of sight, sound, touch and feeling (Schmitt 1999). Where it is further advised that the experience will positively affect emotion through customer satisfaction (Tsaur et al., 2006). This type of marketing would seem to fit within both hedonic and eudaimonic approaches to wellbeing. Where the hedonic approach to wellbeing focuses on pleasures and happiness (Ryan and Deci 2001) and the eudaimonic approach focuses on positive psychological functioning (Seligman 1999).

Scoping existing council resources

From a similar stance, Isabella discusses her perspective about how the fusion of public health and tourism project working could improve the tourism offer and further optimise efficiencies:

“So it’s about...sharpening and scoping the services and the offer that the borough council has” (Isabella, Public Health)

Developing a long-term vision

Strategic future planning

Interview data derived from the interview with Max revealed parts of the strategy behind tourism planning, particularly as it relates to the seafront:

“It’s trying to think long-term about what we’re going to do rather than just spending our money on maintaining and patching up old stuff keeping it going. It’s thinking, how do we develop the offer and keep it moving forwards” (Max, Tourism)

Max and other tourism participants within the study discussed the constant need for innovation and branding, staying ahead of the curve. In looking to future destination branding for the town, participants both with public health and tourism discussed the potential for the town to develop an attractive wellbeing tourism offer for the town.

Connecting the core category to engagement strategies

Rebranding the destination – Knowledge sharing across council

The core sub-category of rebranding the destination is connected to the engagement strategies sub-category of knowledge sharing across council. Participants from both public health and tourism recognised the need for knowledge sharing in order to develop an effective health and tourism branding strategy for the town which is underpinned by eudaimonic and hedonic approaches to wellbeing. Research investigating eudaimonic and hedonic pathways contend that a life containing both types of pursuits will ultimately achieve the highest levels of wellbeing (Huta and Ryan 2010). This assertion has led to a growing number of integrated wellbeing conceptualisations (Huppert and So 2009) which combine features of hedonic and eudaimonic wellbeing, often referred to as flourishing (Seligman 2010). Seligman's (2011) wellbeing theory combines features of hedonia and eudaimonia and proposes that wellbeing consists of the pursuit of one or more of the five elements: positive emotion, engagement, relationships, meaning and accomplishment (which is abbreviated as the acronym PERMA). Study findings would indicate that understandings of wellbeing and associated offers for residents and tourists include both eudaimonic and hedonic elements. Seligman's wellbeing theory presents a theoretical framework that could serve as a planning tool to engage public health and tourism teams in the development of a healthy tourism offer for the town.

The first element in Seligman's wellbeing theory is the pleasant life or *positive emotion* and is what hedonic theories promote (Seligman et al. 2006). The second element is *engagement* which is pursued through engrossment in work, intimate relationships and leisure (Csikszentmihalyi 1990). This desired state is referred to as flow which is a psychological state that is experienced when an individual is immersed in engaging activities (Csikszentmihalyi 1996). The third element in the wellbeing theory is positive relationships that are pursued for their own sake and are accompanied by positive emotion or meaning or accomplishment benefits (Seligman 2011). The fourth element is focused on the pursuit of meaning and is attained by using unique individual qualities and strengths to serve and belong to something larger than the self (Jayawickreme et al. 2012). The fifth component is accomplishment which is motivated intrinsically and is not tied to winning but is driven by a need for mastery and competence (Jayawickreme et al. 2012).

Knowledge sharing is the process whereby knowledge held by an individual is transformed into a format which can be understood, absorbed and utilised by others (Ip 2003). Increasingly, knowledge is recognised as the most significant resource within an organisation (Nahapiet and Ghoshal 1998; Spencer and Grant 1996); and represents the main source of competitive advantage (Stewart 1997). In turn, knowledge sharing

can be understood as being fundamental in the process of destination rebranding which aims to achieve a competitive share of the travel and tourism market.

10.8 Conclusion

The core category of finding ways to engage with a healthy tourism offer is a process that involves: identifying approaches, connecting community members, involving the local population, improving health and wellbeing, considering lifestyles and rebranding the destination. Figure 19 Mapping the connections between the core categories with: the process of change, the role of wellbeing, the context of place, and engagement strategies categories, illustrates the connections between the core category and the other main categories identified within this study. This chapter explicated the conditions, actions/interactions; and consequences of the studied social processes. The chapter identified and explained the central phenomenon of the study, finding ways to engage with a healthy tourism offer; discussed the interconnections between the core and other emergent categories; and increased the explanatory power of the substantive theory explaining how the concept of wellbeing, public health and tourism can potentially be synergised at the local destination level.

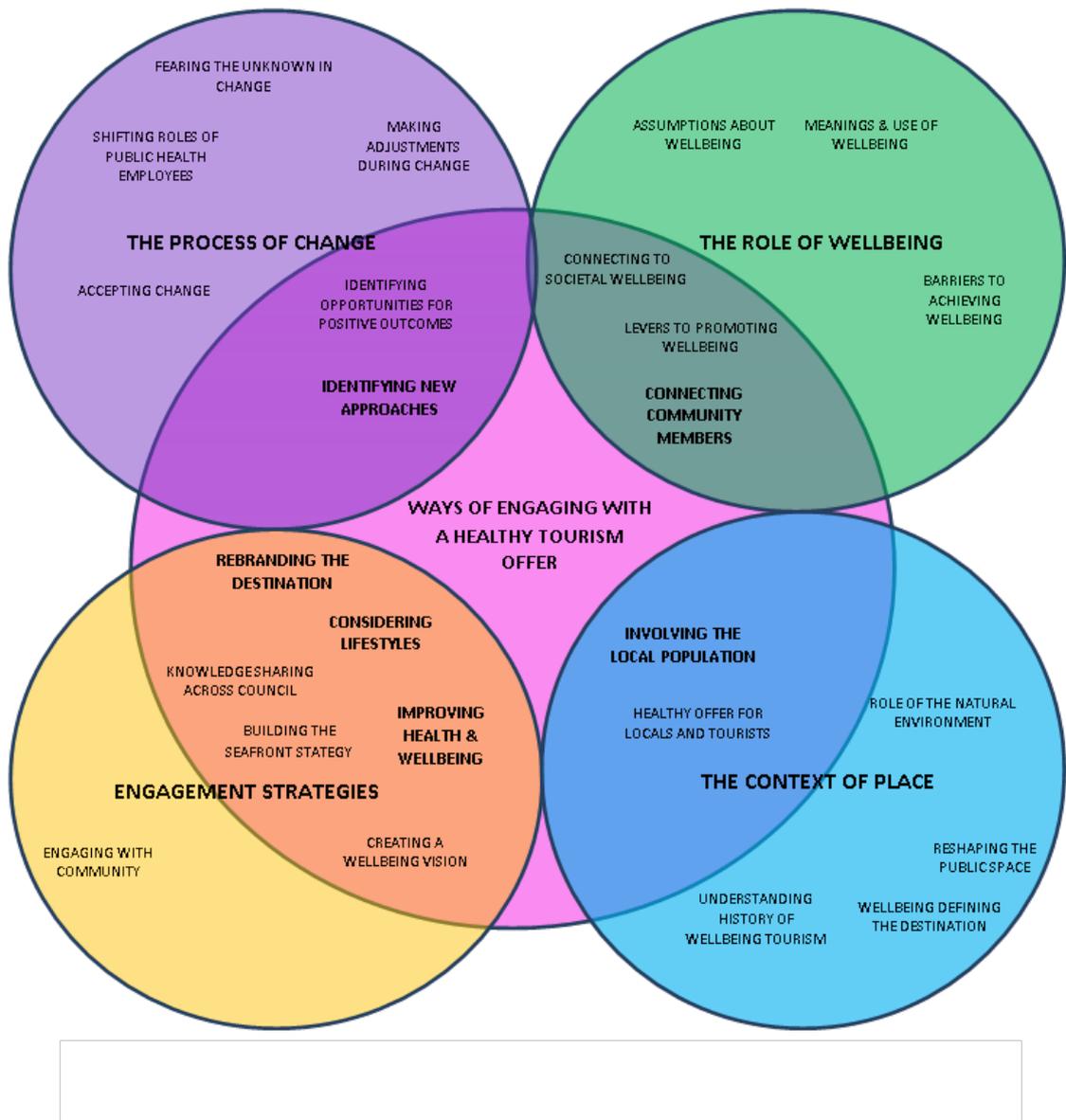


Figure 19: Mapping the connections between the core category with: the process of change, the role of wellbeing, the context of place, and engagement categories

11. STUDY IMPLICATIONS, REFLECTIONS AND CONCLUSIONS

11.1 Introduction

This chapter will present: a theoretical model, an evaluation of the research, reflections of using the constructivist grounded theory methodology, a reflexive stance, the implications for practice, policy and future research, and conclusions about the study.

11.2 Theoretical development

Through the analysis of the findings, the processes for promoting synergies through wellbeing were revealed, beginning with the process of change and leading to the strategies that could lead to a strategic alliance between public health and tourism.

This conceptualisation of the process facilitating the theory to be developed, explains how a strategic alliance could be developed between public health and tourism communities of practice through finding ways to engage with a healthy tourism “offer”. This is discussed as:

1. The process of change; the public health agenda shifting to the local authority, presents a causal condition that could identify new approaches to sharpen existing services.
2. The role of wellbeing amongst members of public health and tourism teams: offers an intervening condition that could connect community members through activities promoting social interaction and eudaimonic living.
3. The context of place features a coastal environment which presents an opportunity to involve the local population to better understand resident expectations and identify corresponding tourist and resident demand.
4. Engagement strategies that consider health and wellbeing, lifestyles and destination rebranding and present experiences to share knowledge about optimal wellbeing activity pathways which further contribute to a sharpened tourism offer.

The phenomenon of *finding ways to engage with a healthy tourism offer* is influenced by four conditions. The first is the causal condition of change which occurred as a result of the shift of the public health responsibilities in April 2013 to UK local authorities. During this process of change, the identification of new approaches could result from members’ recognition that every project that they embark on involves the wellbeing of residents. From a public health perspective, new approaches could also result from the mapping exercise across council directorates identifying the existing and potential connections to the health and wellbeing agenda. From a tourism perspective, new approaches may result from the development of a tourism plan that integrates health and wellbeing infrastructure, activities and events. Consequently, the identification of new approaches

facilitate engagement experiences that, promote innovation through the scoping and sharpening of existing services and present destination rebranding opportunities.

The role of wellbeing is the next condition, recognised as an intervening condition to finding ways to engage with a healthy tourism offer. This can result from council members working to connect community members via the promotion of activities that promote social connectedness, a sense of community and helping others. Collaborative efforts to tackle the impacts of loneliness, particularly among the local elderly population potentially lead to the development of local community led approaches to health improvement that achieve greater levels of community cohesion and, ultimately eudaimonic wellbeing. Therefore, greater opportunities for eudaimonic living, developed through intra-departmental synergies, may improve resident wellbeing through greater eudaimonic activity and event offers.

The context of place is the next condition that influences the central phenomenon of finding ways to engage with a healthy tourism offer. This may result from involving the local population in the development of a healthy tourism offer. Past seafront surveys, revealed that over 60% of the users of the main beach in town were the resident population, thus highlighting the need for seafront planning to consider local expectations in terms of the demand for recreation and wellbeing activities. This provides evidence to support collaborations between public health and tourism departments focusing on the best coastal event and activity offering for both residents and tourists.

Engagement strategies are a condition that could potentially influence council members' means of finding ways of engaging with a health tourism offer, specifically, improving health and wellbeing; considering lifestyles and rebranding the destination, are the processes identified that may contribute to this engagement. After the shift of the public health agenda to the local authority in April 2013, the creation of collaborative forums akin to the 'public health development forum' provided collaborative opportunities for departmental teams to engage with the wellbeing framework. Crossing boundaries between departments required that mutual interests were established in order to transform, share and transfer knowledge. The involvement of all council departments in the development of the wellbeing framework provided occasions for knowledge to be brokered between public health and tourism departments that could further lead to innovative ideas and practice in building a healthy tourism offer for the town.

The consideration of lifestyles, presents another process which may enhance the ability for local members of council to find ways of engaging with a healthy tourism offer. For example, 'zones' planned within the local seafront strategy, the natural zone and the coastal activities park, focus on developing opportunities for people to participate in enjoyable exercise. These particular zones within the seafront strategy consider

healthier lifestyle options for residents and tourists, in turn promoting fusions between wellbeing, public health and tourism. Additionally, there is an increasing demand for healthier options in leisure and holiday time (Keynotes Ltd. 2003; Douglas 2001), that present areas for public health and tourism teams to work together to develop a healthy tourism offer.

Rebranding the destination is identified as a useful strategy that may lead to the central phenomenon of finding ways to engage with a healthy tourism offer. This could result from the transformation of knowledge that considers eudaimonic and hedonic wellbeing pathways within the planning process. Seligman’s wellbeing theory, known as PERMA for its five elements of positive emotion, engagement, relationships, meaning and attachment, provides an example of a wellbeing theory integrating hedonic and eudaimonic elements and may provide a useful planning tool to engage local public health and tourism team members. Using a wellbeing template that considers different wellbeing pathways might help to transform and share knowledge between communities of practice; potentially achieving higher wellbeing outcomes. The diagrammatic representation of the factors promoting synergies between wellbeing, public health and tourism is depicted in Figure 20.



Figure 20: Diagrammatic representation of the factors that promote synergies between wellbeing, public health, and tourism

11.3 Evaluating the research

This study uses the criteria identified by Charmaz (2006) and includes: credibility, originality, resonance and usefulness to assess the value of this constructivist grounded

theory study. The evaluation of the research in this study addresses the questions that Charmaz (2006) recommend be asked of the research, see Appendix 4. The evaluation of this study's research is outlined under each of these four criteria.

Credibility

Charmaz (2006) advises that credibility focuses on the plausibility of the results with reference to the data presented, the analysis, evidence presented to support claims, and the breadth of the data collected. The credibility of the study is acknowledged to be imperative, throughout the research process.

The research presents an intimate familiarity with the topic through an interdisciplinary literature review of wellbeing, public health, tourism and destination management, and the study's discussion and implications were situated within the context of extant literature and empirical study findings. The purposive sample of participants in the study represented a range of council members working at various levels within public health or tourism teams within the town's local government. This range of participants provided a diversity of perspectives about the concept of wellbeing and how it could contribute to collaborations between departments.

Sixteen qualitative interviews were conducted with participants that were recruited from the local public health (formerly the Primary Care Trust) and tourism teams and cabinet members holding relevant portfolios. Interviews were conducted within a booked office, in a location most convenient for the participants to meet. On average, interviews lasted about thirty-five minutes, providing adequate time to explore all of the relevant study themes. Preliminary findings were discussed with colleagues and academic supervisors to ensure that there was sufficient depth to the data collected. Constant comparison was used to compare and contrast different categories, for example, comparison of: meanings and use of wellbeing and connecting to societal wellbeing.

Study participants were recruited from two main local authority departmental settings, public health and tourism. Within interviews, however, examples cited provided a vast range of international empirical settings that included, the workplace, family life, relationships with friends, partners and spouses and vacation time which expanded the range of experience settings.

Emerging data was situated alongside existing literature on wellbeing, public health, tourism, boundary objects and organisational change. The return to literature provided sensitising concepts to apply to field research and further build upon current research. Connections between the data and analysis were confirmed through discussions with colleagues about the data and emergent categories. Preliminary study findings were

shared with colleagues and at two international research conferences, which provided an opportunity for alternative interpretations of the study findings.

Originality

Addressing Charmaz's (2006) criteria to judge originality, the study presented fresh insights into the process of finding ways to engage with a healthy tourism offer: engagement processes may include identifying new approaches, connecting community members, involving the local population, considering lifestyles and rebranding the destination. These findings contribute to the existing work within this field. A key finding is around the types of wellbeing theories and definitions that may lead to synergies between local public health and tourism departments.

Data presented within the study provides a new conceptual framework (Chapter 10) of the factors that influence public health and tourism departments in findings ways to engage with a healthy tourism offer. This framework provides an explanation of the connections between: the process of change, the role of wellbeing, the context of place and engagement strategies and the study's central phenomenon. This explanation of this framework may enable further exploration of the role of wellbeing as a boundary object catalysing interdepartmental synergies. Additionally, the social and theoretical relevance of this study is outlined within the implications section in this chapter.

Study findings challenge the role of organisational change as a phased process (Lewin 1947; Armenakis et al 1999); rather it is evidenced to be an ongoing and dynamic process that may catalyse the development of new approaches which could lead to synergies between wellbeing, public health and tourism. Past research has indicated that boundary objects remain largely under-theorised (Fox 2011); study findings offer a substantive theory which explains how wellbeing may lead to the transformation and sharing of knowledge at public health and tourism practice boundaries. Study findings also contribute to theoretical development concerning brokering processes between communities of practice which was previously noted to be theoretically limited (Pawlowski et al. 2000).

Resonance

To address the criteria of resonance, two dimensions were employed to evaluate the fullness of the studied experience. Theoretical saturation was approached towards the end of data collection, where no new information about wellbeing or areas for potential synergies was introduced in the interviews. In addition, member checking was used to confirm the resonance of the study and the fullness of studied experience. Participants were provided the option to review interview transcripts and amend the document at their discretion. There were not any requested amendments to any of the transcripts.

The study identifies a range of meanings and perspectives about the concept of wellbeing. The taken for granted meanings identified within the study were that health and wellbeing of residents is the legal responsibility of the local authority, and it should be considered in every project within council. This was particularly important to the process of engaging with a healthy tourism offer, as the legal mandate was not always clearly identified by members of the tourism department, thus impacting perspectives regarding potential collaboration.

Connections were identified between larger collectivities and institutions and individual lives. In this study, the role of wellbeing was connected to individuals within a broad range of settings and contexts. Wellbeing was connected to public health and tourism interventions as well as within participants' personal lives and their general perspectives. Study findings identified the role of freedom and autonomy to potential synergies as a means to promote eudaimonic wellbeing, based primarily on participants' personal reflections.

Data analysis offered deeper insights about their lives and worlds through memos that provided reflections about some of the key issues identified by the participants. Often participants who felt that they had a very limited knowledge about what wellbeing meant, reflected on personal examples that revealed the depth of their perspective. Some participants shared how different types of social interactions were connected to personal levels of wellbeing and the importance of interventions to promote greater social connection.

Usefulness

This study recognised that wellbeing meanings and use, could be applied to individual's everyday situations as an important element to both their personal and professional lives. Study findings may be used to better inform council and cabinet members, community organisations and members of the larger tourism community. Evidence from the study identified generic processes around engaging with wellbeing as an important factor in the personal and professional lives of the participants. In the assessment of whether generic processes have been analysed for tacit implications, the study evaluated the process of engaging with wellbeing and recognised that the tacit implications of this process are that wellbeing is part of every project that council embarks on and may play a concealed role in participants' work tasks and job remit.

Data analysis revealed the need for further research in other substantive areas. Study evidence highlighted the ongoing nature of organisational change and need to better understand factors promoting successful change. Findings also underlined a need for additional research around place and the elements contributing to the development of

healthy places. Study evidence highlighted the need for research investigating the boundary crossing competencies necessary to manage knowledge and practice across interdepartmental organisational boundaries.

The study has built upon existing knowledge by outlining that eudaimonic activity pathways and interventions are important to the process of findings ways of engaging with a healthy tourism offer. Further building upon wellbeing and boundary object theoretical frameworks to explain how wellbeing, as a boundary object, could contribute to the development of a strategic alliance between local public health and tourism communities of practice. Within this context, engagement with a healthy tourism offer, has been recognised as a process and strategy.

11.4 Study reflections

Background to this study

I approached this study as an outsider in every possible sense of the word. I applied to the Bournemouth University Studentship from Edmonton, Alberta, Canada. As I recall, I had seen the post and thought that I did not have the background to match the knowledge criteria of the desired candidate. A former work colleague, however, emailed me the post and said that he was convinced that I could find a way to make it fit with my background. I applied for the research post while I was living in northern Canada and working for the City of Edmonton, in the role as a Community Engagement Coordinator tasked with the role of reducing community-wide greenhouse gas emissions. My background was in environmental and climate change engagement and education, so the prospect of working in wellbeing, public health and tourism fields was more than a little bit daunting.

When I arrived in Bournemouth and began the research at the university I felt well outside of my comfort area. I realised quite quickly that much time and thought had gone into the PhD research project, hence, there were already study aims and objectives drafted. One of the toughest parts of beginning the research was claiming ownership over a project that I had not devised and a research gap I had not identified. For these reasons, I initially found it difficult to develop a real passion for the research project.

In early discussions with my supervisory team, I felt that my real contribution to the project could be through my passion for methodological rigour and my background using grounded theory methodology, used in my MSc dissertation the previous year at De Montfort University. In the development of a research plan I promoted the use of grounded theory as I believed it to be the best fit to collect rich data that would best address the research aim and inquiry. I am certain that methodological comfort and background with grounded theory influenced my decision to employ grounded theory within this study.

Approaching the field of study

As my recent experience was with the field of sustainability, sustainable development and climate change, I tended to be more sensitive to these concepts in relation to my literature and fieldwork associated with the research project. Early on in the project, I realised that my main research passion was to better understand human and nature relationships in an effort to promote pro-environmental behaviours. I found the early stages of the project to be quite difficult as the project was concerned with wellbeing and presumably social sustainability thus, I had to work to locate my passion in the current study, to be authentic in my pursuits and to myself. This internal tension that I was experiencing, in turn had an effect on my interactions with all aspects of the research process.

Methodological framework

In the development of the research plan, I did not initially have support to utilise a grounded theory methodological approach, as the study was originally planned to be an ethnographic study. As such, I was required to build a case for using the grounded theory approach to the study. Ultimately, the constructivist grounded theory approach was accepted by my supervisory team as the best fit to address study's research aim. Upon reflection, I recognise that I likely spent more time researching my methodological and philosophical framework than reviewing wellbeing, public health and tourism literature. I definitely tended to work in areas of comfort, early in the project, as I felt out quite out of my depth in all other aspects of my research study and research environment.

Undertaking the study

Prior to arriving in Bournemouth, I had very little knowledge about the local politics, place-based issues or historical antecedents that lead to the town's development. In truth, I had completed my Master's in Climate Change and Sustainable Development at De Montfort University in Leicester and had made an assumption that Bournemouth would be similar to Leicester in some respects, however, what I found was a culture and place that was unlike anything that I had experienced to date. While I lived and studied in Leicester I was part of a social network of environmentally and politically engaged researchers and activists. I was still working to make sense of British politics and how they fit in my Canadian-centric understanding of ideology and political parties. Arriving in Bournemouth, I did not realise how different the political landscape was to that north of London. Much of my time was spent trying to understand differences in language, culture, geography and politics, something I realise that takes much more time than I originally understood.

When beginning data collection through the method of participant observation at the Primary Care Trust (PCT), I had a very few preconceptions, I had a limited knowledge of public health, the National Health Service and the relationship with local council. I was entering the study environment as a Canadian, a female, from a different background, and reference for understanding. As an outsider, I observed employees at the PCT while the public health team were anticipating a great amount of change in their move to the local authority. I observed that people seemed to open up to me about the tensions and concerns that they were currently encountering, that perhaps I was perceived to be a 'safe' person to speak with. As an outsider, I was often unaware of the meanings of much of what was being said both in terms of acronyms and colloquial language. At this point in the study, I was absorbing all of the new experiences and environments, akin to how I would feel when vacationing; all social exchanges and experiences were opportunities to learn.

Identifying my philosophical leanings

One of the most difficult things about embarking on a PhD journey is that some of the learning is uncomfortable as it forever changes the way that you engage with the world. Time spent researching the methodological and philosophical underpinnings of the study was one of the most immersive points in the PhD journey. While I had completed a grounded theory study for my MSc, I had not understood the philosophical underpinning and the relationship to the researcher. Assessing where, as a researcher, I stood along a philosophical continuum, was an unsettling exercise as it forced me to evaluate my core beliefs and values. In situating the study, I was forced to acknowledge my philosophical leanings as an interpretivist and consider why for instance I was not a positivist or pragmatist. Recognising my positionality as a researcher enabled me to better understand some of the tensions in my research journey. The acknowledgement of my positioning also led me to better understand the appeal of certain types of studies and in particular my methodological direction within this PhD study.

Taking a baby break

In January 2015, while working on my PhD and working at a local council, I learned that I was pregnant. While, the most welcome news I could imagine, I could not have anticipated how much pregnancy would shift my focus and perspective. To fund the completion of my PhD I was working at the local council within their Health and Social Care directorate during the day, and in the afternoon I was completing my PhD. As a first time parent, I quickly became immersed in my pregnancy and all the thoughts associated

with expecting. While I was determined to complete my PhD, my body seemed to no longer be under my control, where I required much more rest and antenatal care. At the time, the majority of my energy and thoughts were centred on having a healthy baby. That said, I was not very thesis productive into the spring and summer of 2015 and formally took a break from my PhD from August 2015 until November 2016.

Returning to the study as a parent

Returning to my PhD was a big decision not only for me but for my family as we needed to find resources around finances and childcare to support the pursuit. I was very fortunate to have the support of my partner and his family to allow me to complete this study. Re-reading my thesis chapters, data and analysis proved to be quite an overwhelming pursuit initially, as I had not worked my intellectual mind in over a year. After a couple of months, I found I gained more confidence in my abilities and gradually had greater levels of concentration and focus than I did prior to having a baby. I returned to my thesis on a part-time basis, two days a week, as that is when I had arranged childcare. Seeing the road to completion appeared much clearer in this stage of writing, indeed I felt like a different person. In this context, I found that it was easy to focus for the hours I had allotted to my study when I knew that that I had my little supportive family to return to. In my experience, my PhD journey had been quite lonely as a PhD researcher, which further led to me getting in the way of my own progress and success. Approaching the study from where I stand now, everything looks clearer and I am genuinely appreciative of the experience and the research process – which unfortunately was not mirrored in the first stages of my research. I now feel that there is a balance to my life, that this intellectual pursuit and doing something for me, actually improves my ability to be a parent and to enjoy my time with my daughter.

Position as an insider

I have now lived in the Dorset area for five and a half years, hold a resident permit, and have my own small family with my British partner. In almost every way, I feel like I am part of the community and area that I live in and that I am a local. In the last general election June 15th, 2017, despite not having a vote, I realised that I had a stake in the outcome; the result mattered to my family here. I know that I now use some of the colloquialisms and common vernacular, I have local places that I go because the staff members remember who I am or who we are as a family. I have a community of mum's that have been my most important resource in this most recent chapter of life as they have empathised with some of the emotional struggles associated with shifting from being a woman and career professional to being a mum. I did not know when I accepted this PhD post, that I would stay in Dorset, find my 'person', and start a family. These changes in my life have made a huge difference to how I see and experience the world.

I approach my research from a place of greater understanding and empathy as it is the place I live, issues become more personal as there is now a passion to be the change that I want to see in my community.

11.5 Lessons learned from the process of conducting the study

Limitations of the study

While this study presents an exploration of the potential for synergies between wellbeing, public health and tourism at a local destination, there a number of limitations that have been identified.

This study was based on a town in a unitary authority, which means that it is responsible for all local government services within a district, with public health for the area being governed from the county council overseeing three unitary authorities. If this study were to be conducted within another city or town with different levels of government responsibility and provisions for services, there may have been different thematic areas identified within participants' accounts. Therefore, locating the findings with the context of a time, place, and culture is an important consideration of the constructivist stance to this study.

As this was a qualitative study, there were a relatively small number of participants interviewed. Recruitment challenges led to alternative access routes, yet, recruitment was still limited to the scope of the research question and context of the study which prevented the exploration of access routes within other councils. Consequently, this led to interviews conducted in a range of locations and settings, some within open plan offices when that was the only space available. It is unclear whether the same data would have been collected in different settings or with additional study participants. Also as interviewing techniques improved throughout the data collection process, there is a chance that data collection was not as effective in the earlier stages of research.

Despite the noted limitations, this study does provide a thorough evaluation of how the concept of wellbeing may contribute to the development of a strategic alliance between local public health and tourism communities of practice. This exploration makes a contribution to the literature in the respective fields, specifically those concerning the characteristics of boundary object (wellbeing) and how it can facilitate the brokering of knowledge, organisational efficiency and innovation. The study contributes to knowledge and identifies key areas for future research.

11.6 Implications of the study findings

Implications for practice – local council

An increased awareness of the processes that influence how local council members find ways to engage with a healthy tourism offer, have implications for practice within local council, particularly within the public health and tourism teams. As employees with public health and tourism teams are engaged with council work and business processes, they are arguably well placed to affect recommended change within the organisation.

Change

Implications to practice are, during processes of organisational change managers might consider crafting messages that reflect the range of personal characteristics and social discriminates among employees. As change has been noted to be an ongoing process, managers may want to consider the individual level differences and the constant state of uncertainty that can wear employees out. This is increasingly relevant in light of pending Local Government Reform and Sustainability and Transformation Plans that will trigger a number of changes in local council structure and ways of working. In light of these upcoming and ongoing changes, ways to work more effectively and efficiently across the organisation may in turn transform current business practices.

Directors and managers might want to consider ways to incentivise employees to work across departmental boundaries and engage in collaborative projects which could maximise the quality and quantity of outputs. This may also help to overcome the vertical and horizontal knowledge silos preventing current knowledge sharing, transformation and transfer. The promotion of knowledge brokering activities across work teams may lead to more innovative work practices.

Wellbeing construct

In building a wellbeing framework, it may be worthwhile to consider developing a more inclusive definition that is relevant and meaningful to both public health and tourism communities of practice. To allow greater knowledge sharing between departments, the working definition of wellbeing could contain both hedonic and eudaimonic elements of wellbeing as tourism tends to align more with hedonic wellbeing and public health with eudaimonic wellbeing, generally. For example, the consideration of freedom and autonomy in the development of healthy tourism interventions may co-locate public health and tourism agendas and apply integrated wellbeing theories which consider both hedonic and eudaimonic elements of wellbeing.

Social interactions

In the development of healthy tourism interventions, it would be useful to consider the role of social interactions and connections to wellbeing. Loneliness among the elderly is a notable health challenge as it is associated with negative mental and physical outcomes. In the town, the 2014 census data analysis reports that nearly 18% of the

town's population are over 65 and 28% of the county population are over 65. Projections suggest that this demographic will increase a further 10% by 2024 (ONS 2014). A focus on interventions promoting meaningful social interaction among older populations could offer a means to achieve a social return on investment, further enhancing population level health and wellbeing.

Public consultation

Study findings indicate that a starting point for tourism strategies is self-image, a potential area of concern for both residents and tourists (Warpole 1992). Public health and tourism teams might want to consider collaborative public engagement and consultation strategies. This type of process involving the local population may be a means to better understand place expectations of the local community to compare and contrast with those of the tourists.

Regeneration

Arts-led regeneration might be an area for planning synergies between public health and tourism teams. Working on interventions to improve population health, may raise the level of the area up to open it up as new destination market to be explored. Arts and cultural driven activities and events present a strategy that could lead ultimately to a more diverse, healthy tourism offer, and niche tourism market.

Interventions

Ill-health in the UK accounts for £10.4 billion annual spending, with £4.2 billion related to obesity and £3.5 to alcohol misuse. There is an opportunity for public health and tourism departments to address levels of alcohol consumption and rates of physical activity in their engagement with the development of a healthy tourism offer for the destination. There is an area for synergy between public health and tourism teams to find new tourism destination markets that offer an alternative to the current alcohol-focused night-time economy.

Public health and tourism agendas could be collocated through a focus on making exercise fun. For example, the coastal activities park is a potential area to align strategies. Building upon the pilot project targeting people who are at risk for diabetes, the coastal activities park could develop programmes for residents and tourists which integrate the concept of play into physical activity interventions.

Public health and tourism teams could review the potential for collaboration around arts-led regeneration which could improve population health, in turn raising the level of the area up and presenting a destination marketing opportunity, highlighting arts and culture.

Policy and strategic planning

Wellbeing indicators

In order for governmental departments to have a complete picture of resident wellbeing, it would be useful for local government to measure wellbeing using objective and subjective measures. These types of measures gathered across the town's diverse areas could assist local planners and policy-makers to identify the primary issues and better target policy and strategy development.

Valuation of social interventions

The role of social connection and social capital presents an area to consider in the development of policy targeting equality and health inequalities. Findings reveal the potential impact of investment in community development, a return of 15:1 (Thome and Fisher 2013). New policy directions guided by Local Government Reform and Sustainability and Transformation plans might want to consider the potential value of social intervention and development of social capital in all future policy development.

Promotion of knowledge sharing

Organisational efficiency depends on knowledge sharing and knowledge transfer between departments. Policies to promote an organisational culture which promotes intradepartmental learning and collaboration could lead to greater organisational efficiency and innovation. Policy reflecting a more holistic approach to council's ways of working might provide a means to use resources more efficiently and better integrate knowledge silos.

Alternative tourism branding

Policy and strategies designed to target binge drinking may dovetail local public health and tourism agendas. Alcohol consumption is recognised as one of the factors making the greatest contribution to disease in the county and its misuse accounts for a UK healthcare spend of £3.5 billion annually on ill-health.

Future research

Ongoing change

Study context and findings reveal that change is an ongoing process, contrasting change models which consider the elements of: freezing, moving and unfreezing (Armenakis et al. 1999; Lewin 1947). This constant state of uncertainty that underlines current council work context presents an area for future research inquiry exploring the role of individual level differences in relation to the promotion of successful change.

Use of wellbeing in tourism industry

Study findings highlight the different levels of acceptance of the concept of wellbeing in practice. Within the tourism industry, future research may want to explore the acceptable use of different terms that may include wellbeing, wellness, quality of life and happiness as there seemed to be a notable reluctance to using the word wellbeing with external tourism stakeholders. This future research could reflect on how different sets of assumptions about wellbeing can best inform policy discussion and analysis and highlight the importance of developing more inclusive definitions of wellbeing.

Flourishing

Study evidence highlights the benefits of promoting eudaimonic and hedonic elements of wellbeing, also referred to as flourishing. Future research could measure activities impacts of levels of wellbeing on residents and tourists in order to inform strategic planning and policy – further promoting synergies between public health and tourism communities of practice, further providing evidence about how council practice may promote flourishing.

Relationships to place

The evidence further highlights the need for greater research around the topic of place, exploring opportunities to design healthy places (Frumpkin 2003) with the goal of health promotion through the development of a healthy tourism offer.

This study reveals the dual importance of resident and tourist place relations, currently there remains a gap in research focused on tourist place relations (Manzo 2003; Stokowski 2002). Future research exploring the perceptions of residents and tourists could be useful to mapping the connection to wellbeing and destination management.

In addition, the role of coastal environments or blue spaces on levels of wellbeing is an emergent research area. Future research could examine the influence of coastal environments on individual levels of wellbeing, further informing local planning and policy development.

Boundary objects and knowledge management

Study findings highlighted the need for a greater understanding of the nature of the boundary crossing competencies that are required to manage discourses and practices across organisational boundaries. Future research could focus on the role of the knowledge broker in organisational learning and the promotion of more efficient knowledge management across communities of practice.

11.7 Conclusion

This study has provided an exploration as to how the concept of wellbeing can contribute to the development of a strategic alliance between public health and tourism communities of practice at a local destination. The utilisation of the constructivist grounded theory approach facilitated a research process that is firmly grounded within the collected data. From the study findings, a theory is presented outlining how local council members of public health and tourism teams may find ways to engage with a healthy tourism offer by the adoption of engagement processes that identify new approaches, connect and involve the community, promote healthy lifestyles and rebrand the destination. Study findings have implications for practice, policy and further research.

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13. APPENDICES

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Appendix 1: Interview guide

~ Read through the 'Participant Information Sheet' and request consent for audio-recording ~

BACKGROUND/ROLE/JOB TASKS

(1) What is your current job title/ position?

Prompts:

- *What does this entail?*
- *What is your role in your team?*
- *Main priorities?*
- *Current initiatives/projects?*
- *What office do you work out of?*

WELLBEING USE IN PRACTICE (MEASUREMENT/MEANING)

(2) Does the concept of wellbeing intersect your position and related tasks?

Prompts:

- *In what ways?*
- *Are there ways that it is measured?*
- *Qualitative/quantitative measures*
- *How would you know if it were achieved?*

WELLBEING MEANINGS/ CURRENT SOCIETAL WELLBEING

(3) To you as an individual, what does wellbeing mean?

Prompts:

- *And by you mean? Paraphrase back to them*
- *What do you do to increase your personal wellbeing?*
- *How might you enhance your personal wellbeing?*

(4) What does societal wellbeing mean for you?

Prompts:

- *Do you feel that it is the same thing?*
- *What do you feel that it depends upon?*

(5) What do you feel about the current levels of wellbeing:

- (a) *Where you live?*
- (b) *Where you work?*

Prompts:

- *What do you mean specifically?*
- *Are there any challenges that you note in either area?*

WELLBEING OUTCOMES

(6) How do you feel that wellbeing can best be achieved?

Prompts:

- *Who is responsible for wellbeing? Government, communities, individuals?*
- *How? Where? Who?*

COLLABORATION/ STRATEGIC ALLIANCE POTENTIAL

(7) In your position, are there occasions for you to interact with people working within the tourism/public health department in the local authority?

Prompts:

- *Certain events, workshops, initiatives?*
- *Frequency?*

(8) Are there currently any projects that you are working on that both involve wellbeing and tourism/public health representatives from local government?

Prompts:

- *Do you see any areas for potential synergy?*
- *Do you feel that there is useful knowledge that could be shared within the organisation?*

Do you have any other questions or is there anything else that you would like to share?

Demographic questions:

Sex:	Female ___ Male ___	Post Code: _____
Age:	18-30 ___	Education:
	31-40 ___	Grammar School _____
	41-50 ___	High School _____
	51-60 ___	Vocational/Technical _____
	61&up ___	Some college _____
		College (2 year) _____
		University (3-4 year) _____
		Master's degree _____
		Doctorate _____
		Professional Designation _____

Thank-you for taking the time to contribute to this research project. Do contact me if you have any additional questions. I may be in touch if there are points that need greater clarification.

Appendix 2: Participant information sheet

Bournemouth University Research Project: Synergies in wellbeing, public health and tourism

Purpose of the interview

This in-depth interview seeks to explore how wellbeing, public health and tourism may be synergised at the local level. You have been selected as an interviewee based on your role and knowledge as it relates to this project.

I will ask you questions about your thoughts and interpretations related to wellbeing, where there are no right or wrong answers. What you share with me may contribute to a greater understanding of the potential for a strategic alliance between public health and tourism as synergised through wellbeing.

Dissemination of the research

The research is part of a PhD research project at Bournemouth University. The data collected from this study will be disseminated for academic-related purposes.

Anonymity

Your anonymity will be protected as your name will be immediately switched to a pseudonym.

Interview format

This semi-structured interview is estimated to last for about 30 minutes. And will be digitally recorded, subject to your permission, so that I am able to give you my full attention during the interview.

Confidentiality

Strict ethical standards are being maintained throughout this project. Any material you provide is held confidentially and published in a format that does not identify individuals. The digitally recorded interview data and any contact information will be stored securely and destroyed after completion of this study.

Thank-you in advance for your assistance with this research project. If you would like to know more about the research project or have any questions, please contact me, see my contact details below.

Stacy Wall

PhD Researcher

School of Tourism – Bournemouth University

E-mail: swall@bournemouth.ac.uk

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Appendix 3: Participant pseudonym selection list

PSEUDONYM	NAME	DATE
Alexander		
Amelia		
Ava		
Charlie		
Chloe		
Daisy		
Daniel		
Dylan		
Ella		
Emily		
Emma		
Ethan		
Evie		
George		
Grace		
Harry		
Isabella		
Jack		
Jacob		
James		
Jayden		
Jessica		
Joseph		
Joshua		
Lewis		
Lily		
Logan		
Lucas		
Lucy		
Madison		
Maisie		
Mason		
Max		
Megan		
Mia		
Michael		
Noah		
Oliver		
Olivia		
Poppy		
Ruby		
Sophie		
Thomas		
William		

Appendix 4: Credibility, Originality, Resonance and Uniqueness theory evaluation questions

Credibility

- Has your research achieved intimate familiarity with the setting or topic?
- Are the data sufficient to merit your claims? Consider the range, number, and depth of observations contained in the data.
- Have you made systematic comparisons between observations and between categories?
- Do the categories cover a wide range of empirical observations?
- Are the strong logical links between the gathered data and your argument and analysis?
- Has your research provided enough evidence for your claims to allow the reader to form an independent assessment – and agree with your claims?

Originality

- Are your categories fresh? Do they offer new insights?
- Does your analysis provide a new conceptual rendering on the data?
- What is the social and theoretical significance of this work?
- How does your grounded theory challenge, extend, or refine current ideas, concepts, and practices?

Resonance

- Do the categories portray the fullness of the studied experience?
- Have you revealed both liminal and unstable taken-for-granted meanings?
- Have you drawn links between larger collectivities or institutions and individual lives, when the data so indicate?
- Does your grounded theory make sense to your participants or people who share their circumstances? Does your analysis offer them deeper insights about their lives and worlds?

Usefulness

- Does your analysis offer interpretations that people can use in their everyday worlds?
- Do your analytic categories suggest any generic processes?
- If so, have you examined these generic processes for tacit implications?
- Can the analysis spark further research in other substantive areas?
- How does your work contribute to knowledge? How does it contribute to making a better world? (Charmaz 2014)

Appendix 5: List of publications

Wall, S., Hemingway, A., Curtin, S. 2017. *Engaging with a healthy tourism “offer”: strategies to improve place perceptions. World hospitality and tourism themes, 9(5).*

Hartwell, H., Hemingway, A., Fyall, A., Filimonau, V., and Wall, S., 2013. Tourism engaging with the public health agenda: can we promote 'wellville' as a destination choice? *Public health, 126, 1072-1074.*

Hartwell, H., Hemingway, A., Fyall, A., Filimonau, V., Wall, S., and Short, N., 2013. Building tourism & wellbeing policy engaging with the public health agenda in the UK. In: Smith, M., and Puczko, L., (eds). *Health, tourism and hospitality: spas, wellness and medical travel. 2nd Edition.* Routledge: Abingdon, 397-402.