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A Story of Strategic Change: Becoming a Social Enterprise in English Health and Social Care

Introduction

Over recent decades, policy developments in public sector reform have increasingly emphasised the decline and fragmentation of established welfare bureaucracies. The disaggregation and decentralisation of services has led some to suggest that welfare systems are becoming more like hybrids as sectors and boundaries become increasingly blurred (Evers and Laville 2004; Billis 2010). Health and social care has been a key area for such changes. The opening up of organisational and institutional boundaries has intended to create greater competition and choice with new service providers (Denis et al 2001; Allen 2009). In England, one such provider has been social enterprise, which has been encouraged as a more innovative and responsive alternative for service users and healthcare staff.

A number of perspectives have been put forward to explain these changing governing arrangements that increasingly emphasise social enterprise. Alcock (2010) suggests that based on its closer commitment to policy engagement there now exists a new-found 'strategic unity' across the third sector. In relation to social enterprise, Teasdale (2010) highlights how policy makers are increasingly using the organisational form as a discursive vehicle to address a wide range of social problems. Nicholls (2010) explains that the recent organisational legitimacy of social enterprise has been as the result of a dynamic interplay between macro-level institutional structures and micro-level organisational actors. Government foundations, such as network organisations like the Social Enterprise Coalition (SEC) represent 'paradigm-building' actors that have been influential in establishing discourses, narratives, and ideal types that characterise the early stage development of social entrepreneurship (Nicholls 2010: 616)

Whilst these explanations about social enterprise and the third sector more widely document important policy developments, changing institutional relationships and discursive shifts, there is a paucity of research studying the experience of individuals in public sector institutions who are establishing social enterprises. This is particularly the case in health and social care. There are examples of research looking at particular aspects of social enterprise in this service area, including access to funding, social enterprise policy and the motivations associated with social enterprise (Miller and Millar 2011; Hall et al 2012) but to date there is very little in the way of in-depth research looking at the process and dynamics of becoming a social enterprise. There is a distinct lack of research concerning how healthcare professionals shift from being part of the public sector to part of the social enterprise non profit sector.

The purpose of the following article is to analyse the process of becoming a social enterprise in English health and social care. The article utilises a strategic change perspective to understand how healthcare professionals responded to the Right to Request (RtR) policy initiative that aimed to support existing NHS staff to establish social enterprises. The article begins with an overview of social enterprise in the context of health and social care reform in England. It then outlines the strategic change perspective being taken before presenting empirical findings about how NHS staff interpreted the process of setting up a social enterprise. The article then suggests these findings reflect the 'sensemaking' of how actors leading the RtR understood and interpreted becoming a social enterprise. They also reflect the 'sensegiving' of actors as they attempted to communicate this process to others in order to influence and gain support from their own organisation and the wider health and social care system. It concludes suggesting that the success of any strategic change to social enterprise will depend not only on the ability to implement new structures and processes, but also on the ability to convey the new mission and priorities to the existing health and social care system.

Social enterprise and English health and social care reform

Over the last two decades significant healthcare reforms have been undertaken in many OECD member countries as government agendas demand greater efficiency and effectiveness in response to an increasingly ageing population, advances in medical technology, ever rising healthcare costs, and heightened public expectations. As with elsewhere, a supply side reform agenda has been introduced in England that focused on increasing patient rights through greater competition and choice. Within the market reform agenda, social enterprise organisations are being viewed as vehicles with the potential for dealing with complex social needs that create social as well as economic capital through innovation and responsiveness (Allen 2009). Social enterprise is broadly defined as 'business[es] with primarily social objectives whose surpluses are principally reinvested for that purpose in the business or in the community, rather than being driven by the need to maximise profit for shareholders and owners' (DTI, 2002).Through their ability to combine business values with social objectives, such organisational forms are presented as an attractive proposition in providing 'value-added' services and mobilise 'pro social behaviour' compared to for-profit private enterprises (e.g. Allen 2009; Peredo and McLean 2006; Nicholls 2006; Thompson 2008).

In the English NHS, policy initiatives encouraged social enterprises on the basis that such organisations would give greater freedom by empowering staff and improving quality through innovation and responsiveness (DH 2006). A Social Enterprise Investment Fund (SEIF) was established to support the development of new enterprises and encourage existing social enterprises to extend into the delivery of health care. A Pathfinder Programme began in 2006 for existing social enterprises who wanted to extend their range of health and social care services and partnerships (DH 2010).

In the primary and community health sector, social enterprises were one of the organisational forms that could be considered under the Transforming Community Services programme (DH 2009). This policy commitment was highly significant in that NHS employees were to be given a 'Right to Request' (RtR) to set up social enterprise organisations to deliver community health services. The RtR scheme (DH 2008a) was designed to enable staff providing community healthcare services to 'spin out' into social enterprises. The Department of Health (DH) guide produced to promote and explain the process (DH 2008b) explained that the benefits of RtR for staff include that social enterprise can create conditions where they can 'innovate and lead rather than being told what to do'. The guide also included benefits for other groups including: patients, as the new organisations would have 'the independence, flexibility and responsiveness to innovate and improve services and outcomes'; wider communities, as the 'new organisations would have profits to invest in the community'; commissioners, through enterprises developing 'services to address the wider determinants of health'; and the public finance as a whole, as 'organisational efficiency would be achieved through less-bureaucratic processes and a more engaged staff-group (DH 2009: 8).

The RtR application process centred on prospective organisations (from small groups of clinicians to large provider organisations) submitting an expression of interest to the Primary Care Trust (PCT) commissioning board. On approval by the Trust board and endorsement by the Health Authority, the leader of the prospective organisation developed a five-year integrated business case that engages with staff and wider stakeholders. This 'milestone process' was often supported by guidance developed by the Social Enterprise Unit and financial support from the SEIF to help develop plans and apply for start-up funding. If successful, the social enterprise was also awarded a contract from the PCT to deliver services for up to five years (see also Miller et al 2012).

Fig 1. The Right to Request process

Becoming a social enterprise: a strategic change perspective

Social enterprises represent a significant development in the health and social care landscape. The RtR scheme formed a key component of externalising services through encouraging the delivery of health and social care by social enterprise (NAO 2011). Existing research on RtR organisations reported some notable opportunities in becoming a social enterprise that included greater innovation in clinical service delivery; the provision of a wider range of services; and efficiency savings from reduced staff absence (Miller et al 2012;

Hall et al 2012; Miller and Millar 2011; NAO 2011). These findings support wider research on non-profit organisations in healthcare settings suggesting that they have the potential to achieve better relations with those they serve, enhance quality and deliver more innovative service provision (e.g. Heins et al 2010; DH 2009; Lewis et al 2006).

Alongside these opportunities, research also identifies challenges associated with social enterprise entry into existing healthcare services. Miller and Millar (2011) found only limited interest expressed by NHS staff to develop RtRs due to a lack of staff support, leadership, organisational support and commissioning support. A dependence on NHS commissioning as the dominant source of work was also a problem as competing initiatives and institutional inertia challenged social enterprise entry. Commissioners have been highlighted as particularly problematic as they may equate social enterprises with being 'not business-like enough' (Baines et al 2010: 54). Workforce concerns regarding job security, business skills and the potential loss of public sector branding have also been documented (Sankelo and Akerblad 2008; DH 2010), as well as the difficulties in measuring anticipated benefits and securing funding from financial institutions and commissioners in a competitive market place.

Our interest in this ever expanding area is to understand the processes and practices associated with how healthcare professionals responded to the RtR policy. In doing so, we are interested in the strategic change associated becoming a social enterprise. This perspective seeks to understand how organisations change structures, processes, priorities and goals to take advantage of opportunities or to cope with environmental threats (Gioia et al 1994: 364). It focuses on how organisational leaders articulate impending change through sensemaking and other symbolic practices (e.g. Gioia and Thomas 1994; Smircich 1983; Weick 1979).

The analysis of strategic change has been at the centre of a growing literature in both the strategy and organizational theory fields. Regner (2008) suggests that strategic management theories have traditionally proposed grounds for competitive advantage with in-depth, detailed descriptions of strategy development (Johnson 1987; Pettigrew 1985). Despite this, there are limited accounts of the dynamics involved in the build-up, development and change of organizational assets (i.e. resources and capabilities) that provide for competitive advantage (Cockburn et al 2000). Some studies in the literature (Eisenhardt and Martin 2000; Teece et al 1997) have emphasised organisational processes but they have engaged less with the detailed activities these entail, and with how people perform such activities.

Regner (2008) suggests that recent interest in the 'strategy-as-practice' approach can provide insights into the micro-foundations of the dynamic process through which organizational assets are created or modified (Johnson et al 2003; Whittington 2006). It regards strategy as an ongoing activity and accomplishment, as something people and firms do rather than have (Jarzabkowski 2004) and thus emphasises the day-to-day activities of people on multiple organisational levels (Johnson et al 2003; Whittington 2006). The strategy-as-practice approach also draws attention to the influence of social, cultural and cognitive contexts (Jarzabkowski 2005). Here, strategy making is a situated activity that depends on specific contextual configurations (Jarzabkowski 2004; Whittington 1992) with

social structure and institutions for practice underpinned by social theory (Bourdieu 1990; Giddens 1984). This is in accordance with previous research, which has demonstrated how specific institutional and cognitive contexts influence strategy (e.g. DiMaggio & Powell 1983; Oliver 1997; Weick 1979) and how new assets and knowledge development are contextually dependent (Tsoukas and Vladimirou 2001). Whittington (2006) states that in their different ways, practice theorists are concerned with how social 'fields' (Bourdieu 1990) or 'systems' (Giddens 1984) define the practices (shared understandings, cultural rules, languages and procedures) that guide and enable human activity.

Whittington (2006) suggests there is a growing body of work on the influence of strategy practices on whole societies or sectors (e.g. Knights and Morgan 1991; Oakes et al 1998; Whittington et al. 2003; Grandy and Mills 2004) and intra organizational strategy activity (e.g. Jarzabkowski and Wilson 2002; Maitlis and Lawrence 2003; Samra-Fredricks 2003). The area of strategy we are interested in concerns the significance of social interactions between top managers or leaders within organisations (Jarzabkowski 2005; Balogun and Johnson, 2004; Samra-Fredericks, 2003). For example, Rouleau's (2005) analysis of entrepreneurs in strategic change focused on the important role of sense-making and sense-giving in the interactions with external stakeholders during implementation (Rouleau 2005). Corley and Gioia (2004) studied organisational identity change in the spinoff of a company's top-performing organizational unit into an independent organisation. They examined the processes by which the labels and meanings associated with the organisation's identity underwent changes during and after the 'spin-off', as well as how the organisation responded to these changes.

To understand the strategic change associated with becoming a social enterprise, we too are interested in analysing the processes of sensemaking and sensegiving whereby a new vision or interpretive scheme of the business environment must be developed and communicated to others to gain their support and guidance for action (Gioia and Chittipeddi 1991). Rouleau (2005) outlines how Gioia and colleagues define strategic sensemaking and sensegiving as two complementary and reciprocal processes. Sensemaking has to do with the way actors understand, interpret, and create sense based on the information surrounding the strategic change. Weick et al (2005) suggest sense making involves the ongoing retrospective development of plausible images that rationalize what people are doing. Sensegiving is concerned with the attempts to influence the outcome, to communicate thoughts about the change to others, and to gain their support. Sensegiving is a sense making variant undertaken to create meanings for a target audience. Since strategic change generally involves the reordering of priorities and the disruption of established relationships, the perspective analyses the symbolic processes that aim to create and legitimate the meaning of strategic change (Gioia et al 1994).

Methods

Our interest is in understanding the strategic change processes and practices associated with becoming a social enterprise. To do so we studied a selection of organisations that applied to the RtR and focused on the actions of those involved in leading RtR initiatives. The methods we employed supported recent literature on strategic change that take a 'narrative turn' interested in how actors construct and diffuse stories surrounding strategic change (e.g. Hill and Levenhagen 1995; Rouleau 2005; Corley and Gioia 2004), with the study of interpretation and meaning systems being of fundamental importance (Bartunek 1984; Rabinow and Sullivan 1979; Daft and Weick 1984; Weick 1979). As Barry and Elmes (1997) suggest, attention to narrative is well positioned for capturing the diversity and complexity present in strategic discourse. Narrative highlights the discursive, social nature of the strategy project connected to cultural and historical contexts (Smircich and Stubbart, 1985). It also addresses how leaders are able to fashion stories that 'concern issues of personal and group identity' (Gardner 1995: 62). This narrative view of strategy explores ways in which organisational stakeholders create a discourse of direction (whether about becoming, being, or having been) to understand and influence one another's actions.

In this article we use the terms narrative and story to refer to thematic, sequenced accounts that convey meaning from implied author to implied reader. To examine how the 'meaning' of the RtR policy was understood, the research employed semi-structured conversational interviews with actors who we identified as being centrally involved in the RtR process. These asked questions that aimed to surface key aspects of the RtR process beginning with the motivation to apply, what the national scheme was trying to achieve, why the RtR was successful or unsuccessful, reflections and recommendations about the process (see also Hall et al 2012; Miller et al 2012). Interviews were conducted by telephone and lasted 40 to 90 minutes in length.

Conscious to capture the variation in the process, our sample was based on 6 successful and 10 unsuccessful actors that were leading Right to Requests (n=16). 'Successful' actors were part of organisations that had their RtR approved by commissioners, and had or were about to become social enterprises. 'Unsuccessful' actors were part of teams that did not achieve RtR status, either due to their application being unsuccessful or their attempt broke down in the earlier planning phase (see Fig 1). The sample of RtR organisations was obtained through a combination of convenience and purposeful sampling. Pre-existing work on RtR activity (Miller and Millar 2011; Miller et al forthcoming; Alcock et al forthcoming) had identified 38 RtRs to have been successfully launched. In addition, at least 22 RtRs were unsuccessful at the application stage with many others not progressing past the expression of interest stage (total numbers not recorded). From this mapping work, a convenience sampling strategy then approached a selection of these organisations to capture the micro dynamics of how the RtR played out in practice. This began with an email or phone call to each organisation where the RtR lead was identified and contacted directly.

Like Corley and Gioia (2004) who followed Lincoln and Guba's (1985) guidelines for 'purposeful sampling', we purposefully chose informants within each organisation who were

able to describe their experience of RtR and becoming a social enterprise. Though susceptible to the limitation of bias in selecting particular organisations, the 16 actors involved in the research were selected to represent a diversity of areas and organisational forms. These included those leading large whole community provider spin outs delivering a range of primary and community services, and smaller scale services responding to specific patient and service user needs (e.g. substance misuse or children's services). The professional background of these individuals also varied. Some were practising clinicians that included nurses and general practitioners. Others were operational managers of the organisations or team looking to go through the RtR process. The sample was predominately made up of women with the exception of two men, which reflects previous research that women are widely represented within third sector organisations, as well as the health and care sector (Teasdale et al 2011).

Data analysis of the strategic change employed a framing perspective to capture how those leading the RtR understood and enacted their organizational environment. As used in the literature on social movements (e.g. Benford and Snow 2000), the framing perspective aims to understand the 'schemata of interpretation' that actors use to affect the interpretation of events among different audiences, in particular how actors framed strategic change to secure the understanding and support of key stakeholders (Fiss and Zajac 2006: 1174; Hensmans 2003). Data analysis paid particular attention to the stories about RtR, particularly how the RtR translated into the way people accomplish their day-to-day work. This coding of the data was both inductive and iterative in focusing on passages of text that illuminated this process (Strauss and Corbin 1990; Miles and Huberman 1994). From reading and re-reading these passages of text it became apparent there were distinctive frames to organise, shape and classify experiential material (Benford and Snow 2000). This identified collective frames in relation to contextual 'problems', 'opportunities', 'challenges' and reflections on 'success' and 'failure'. These findings defined the various 'world views', prescriptions and practices for actors in their association with the RtR (Surel 2000, 496).

Findings: Becoming a social enterprise in health and social care

In the following sections we set out how individuals leading the RtR made sense of becoming a social enterprise and the different ways in which this vision was communicated to other organisational members. We also identify the limitations and challenges faced in achieving these goals, particularly the relationships and tensions between RtR organisations and existing health and social care institutions and structures.

The problem: externalisation and the fork in the road

Leaders described how the principle driver for becoming a social enterprise was based on the government policy requirement for primary care commissioning organisations to divest their provider services. The Transforming Community Services (TCS) agenda (DH 2009)

provided the backdrop for this purchaser-provider split, and led to members of provider organisations being directed to 'spin out' of the existing framework under the RtR initiative.

> *Our journey, to some degree, I can't speak for everybody, has really reflected a lot of the policy... the momentum that is being created, I think, has been facilitated by TCS, you know, people started to see their destinies being played out ... people felt very, very anxious... (Primary Care Service Lead)*

This context of organisational flux and uncertainty meant that these individuals were required to assess the options for the existing organisation. As the primary and community care market opened up, depictions of 'the end of the road' and 'the writing on the wall' for how the NHS was changing meant other options were needed. It was during this decision making process that they began to believe that the RtR was the best option to preserve the service. Rather than going out to open tender and being susceptible to private sector takeover or the service dissolving, the decision was made to submit a RtR and develop a business case. Social enterprise was the best vehicle for retaining the strengths of the services being provided.

> *At the time the other options didn't seem very attractive because they involved going into organisations where we'd actually be quite a small component....So community staff in particular who've always felt to be the Cinderella service, it was quite an attractive way of really giving this organisation a high profile. (Community Service Manager)*

Seeing the opportunities of social enterprise

Those leading RtR described how they believed there were entrepreneurial opportunities in moving their service to a social enterprise. This provided the best option in freeing the service by providing more independence and scope for innovation that contrasted with the experience of working within NHS rules and regulations. The RtR was therefore a chance to diversify and develop different types of services.

> *It is an opportunity for all of us as NHS clinicians to request to shape and run our own services... I felt there was an enormous lot we could do to deliver on public health as well as on the clinical stuff around urgent care needs... (Children's Nurse Lead)*

Social enterprise also brought a stronger sense of ownership that staff could relate to. Where NHS processes were seen as cumbersome and surrounded by 'red tape', social enterprise was less bureaucratic and being a social enterprise meant that any surplus would be reinvested into developing services and staff. Social enterprise provided an opportunity to empower staff and users.

...all the things you tear your hair out about the NHS...we were never naive enough to think that we'd eradicate those things... But I think there would have been freedoms to do certain things in different ways... so it did make us think we could actually be much more empowered to run health services how they should and could be run. (Community Service Manager)

Alongside these opportunities for collective ownership was the opportunity for individual entrepreneurial action. Those leading the RtR believed that social enterprise resonated with them as individuals. For example, the RtR opportunities resonated with individual clinicians in enabling them to lead and manage their organisation, freeing them up to help those that needed it most. Others described how social enterprise resonated with the image of themselves as 'odd souls' open to new ideas and ways of delivering services. Where previous opportunities had passed by, this was an opportunity to seize the moment and make positive service changes. This was particularly the case for those leaders who were near the end of their professional careers and were keen to try and make a difference for the future of the organisation.

Seeing the challenges of social enterprise

Whilst the RtR was an opportunity for these actors, becoming a social enterprise also presented a number of challenges. The primary challenge described by those leading the process was balancing the clinical aspects of day-to-day delivery and the managerial aspects of running a business. Some were able to draw on previous bid-writing experience so were confident in their new business roles; however the majority struggled with the challenge of becoming 'business minded' in a short time frame. Developing the business skills to run a social enterprise effectively required a huge amount of work and professional development outside of the day job:

I'd never seen a gant chart before and it had to be put away in the cupboard because I was just freaked by it. We'd never seen anything so intimidating in our lives... it would've been so great to have the opportunity to grow that business head before diving in. As a clinician, suddenly having to go from being a dare I say it, a competent clinician and very comfortable in that to being pushed way out of my comfort zone to running a company and that's a huge transition. (Primary Care Service Clinical Director)

Balancing the roles and responsibilities of being a clinician with a business manager was also a challenge. As a result, these leaders often changed the way they described their roles, responsibilities and job titles according to the context they were in.

When I introduce myself, depending on where I am and what context, I'll either be introducing myself as one of the executives where my title is director of nursing and development because that's that bit or if it's clinical then I'm consultant nurse. (Primary Care Service Clinical Director)

Communicating the opportunities of social enterprise

Once the decision had been made to go down the RtR route, actors described how they ensured the rest of their organisation and wider stakeholders understood and embraced social enterprise as the favoured organisational form. A variety of these 'sensegiving' visions were presented. The most prominent of these was the belief that the move to social enterprise was a collective effort. Rather than an individual pursuit, the process was built on working together as a team. The notion of learning together proved to be the key element to RtR. Within this, staff had greater automony and more freedom to bring their ideas to the agenda. Staff were to be given better incentives and reward systems in order to encourage recruitment and retention.

> *We had this quite exciting dynamic where people in that room then went back and converted people in the workplace that this really was quite a really innovative thing to be doing. And it started almost spiralling out of control in a positive direction for probably about 40% of our staff who were really quite turned on by it. (Community Service Manager)*

> *It is about team effort, it's never about individual people. I know that myself and [colleague] are very passionate about what we do but actually, we'd be nothing without the team. So it really is a team effort. (Social Exclusion Clinical Director)*

The collaborative process was also illustrated in the fact that the decision to proceed in with the RtR was based on a democratic, collective vote with a secret ballot.

> *We had a secret ballot, a secret so as in anonymous ballot and staff voted for their preferred option based on the information that they'd received from an independent source. There was 100% support. Every single staff member wanted the service to be preserved and wanted us to become a social enterprise. So on behalf of the team I exercised our Right to Request formally to the chairman of the board at [PCT]. (Social Exclusion Clinical Director)*

Others sought to communicate the financial advantages of becoming a social enterprise. Being independent would make them better positioned in commissioning processes, as they could bid for contracts not eligible to them as an NHS organisation. They could also use their status as a social enterprise to apply for other sources of funding, including public sector loans and grants from funds such as the Social Enterprise Investment Fund. In addition, social enterprises are considered more efficient as 'money goes to frontline services'. This in turn creates social value for patients and the wider community through the reinvestment of surplus. This was contrasted with a private sector focused on creating profit for shareholders. One actor described communicating to their organisation the evidence associated with social enterprise.

I took it to the last final meeting where I said, "Look, here is strong international and national evidence that if your workers are empowered within the nature of the organisation then you get… Your sickness drops off, you have almost self regulatory staff within the team, because they won't carry any slack" (Childrens Nurse Lead)

Institutional and structural challenges to social enterprise

The sensegiving associated with social enterprise communicated the vision, values and the service changes these actors wanted to achieve. Whilst these sensegiving strategies were largely positive in presenting how social enterprise would bring benefits, there were a number of challenges to this vision. Here, actors described personal pressures of being criticised and verbally attacked for going down a social enterprise route. They had to allay a number of fears associated with leaving the institutional 'safety' of the NHS. This was particularly the case in relation to employee rights about whether staff would still be allowed the same terms and conditions as NHS organisations. In particular, they had to dispel rumours that pensions were safer in the NHS than in a social enterprise.

We did a lot of work just explaining what social enterprise was and one of the reasons behind it. And the staff, easily 70% of the staff as soon as we started talking about it were supportive and actually almost... we could actually still offer same terms and conditions when we moved to a social enterprise model. (Community Service Lead)

Some experienced problems within their own organisation. For example, a leader struggled to promote RtR as it was resisted by the clinical lead of the service unit. They attempted to subvert the social enterprise course of action.

She had said very clearly we couldn't request social enterprise... So I puzzled over it and carried on with the hard work [as it] clearly stated every NHS clinician or group of clinicians did have a Right to Request social enterprise. I thought, well, how and why would our Trust say we haven't? She said, "I wouldn't suggest you do it as a standalone right now,"... she'd put out some slightly scary stuff, telling staff that if the tender for Right to Request… failed people would lose their jobs, and it was really quite frightening stuff... (Community Service Manager)

The central challenge in relation to RtR was communicating the vision of becoming a social enterprise to existing NHS primary care commissioning organisations. Whilst some documented positive relationships and support from commissioners, the majority experienced resistance from NHS commissioners who wanted organisations to be procured or merged with an existing NHS organisation.

The PCT on the surface were supporting us but underneath they didn't want the case to go forward. And to such an extent that behind the scenes they actually tried to

put pressure on the managing director of the Community Health Services to get the elective care manager to pull the bid out. (Community Service Lead)

The way in which the RtR was timetabled by the PCT was also seen as further evidence that they did not want the change to social enterprise. Those that were unsuccessful in completing the RtR process felt that they were not given all of the information or made aware of support and guidance until the very last minute. A leader of RtR described how it was only an hour before they had to submit that they were given the necessary legal information.

Explaining Right to Request success and failure

The experience of those enacting RtR described how social enterprise spin outs were new and very much an unknown quantity in the English NHS health and social care sector. As one actor remarked, 'it was new to everybody so it was a bit like the blind leading the blind'.

It was uncharted waters a bit here… things do go wrong, but we think it's quite good in a way because it puts us in a good position for the future (Primary Care Nurse Director)

Two important outcomes from the RtR process were identified. Regardless of whether organisations were successful or unsuccessful, the RtR brought 'critical reflection' for the leaders themselves and their organisation.

The actual plusses of going down that route, you suddenly understand your organisation an awful lot better in a very short period of time, in a way that I can't imagine another way that would have actually given you that information (Community Service Lead)

What also emerged from this process was staff engagement. These leaders learnt 'important lessons' about staff engagement.

You can have all the vision in the world, but you've really, really got to understand the range of concerns and issues (Primary Care Sevice Lead)

Those that were successful in completing the RtR drew attention to how certain contextual factors were more favourable in enabling them to proceed. Mentors and ongoing formal and informal support from organisations with previous experience of 'spinning out' proved to be a crucial factor within the process. NHS commissioner support and legitimacy was also crucial. For example, a local NHS commissioner became a sponsor and acted as a champion for one organisation.

The PCT had actually given us a bit of a golden handshake the first year... The social enterprise has been very successful, it's because there has been absolute total

support from the PCT to make it happen... I think it's absolutely critical that there should be full commissioner support to make something happen.... I don't mean, yes we'll give you some money, I mean that the desire to make it happen is just as much on the side of commissioners as it is on the side of the provider (Prevention Service Lead)

Conversely, those that were unsuccessful described how NHS commissioning boards prevented them going any further. A number of explanations were put forward for this rejection. These centred on the risks associated with disrupting the existing health and social care system and the faith placed in existing NHS acute or community services. In hindsight, some wished they were better prepared and were more familiar with the government policy agenda. They expressed regret that they did not have leadership skills to manage the politics of organisation restructuring.

I guess I'm not an ace politician, that's my problem, I need to be a bit more politically adept, I think (Community Nurse Lead)

Strategic change and social enterprise in health and social care

The findings presented above capture the experience of public sector healthcare professionals in their attempt to establish social enterprises. By presenting the activities associated with becoming a social enterprise these findings reflect a process of strategic change. They reflect organisational leaders articulating how organisational processes, priorities and goals changed to take advantage of opportunities and cope with environmental threats (Gioia et al 1994: 364; Smircich 1983; Weick 1979). Furthermore, these findings show how the strategic change to social enterprise was a situated activity that depended on institutional and cognitive contexts. By considering these dynamics we start to consider what it means to lead such changes within current healthcare contexts. Such findings are highly significant as the growth of such organisational forms is likely to continue in healthcare but also the public sector more widely.

Like others (Rouleau 2005; Gioia and Chittpeddi 1991; Gioia et al 1994), when we consider the implication of these strategic activities we do so from the perspective of sensemaking and sensegiving processes. These findings show elements of sensemaking in the way actors understood and interpreted social enterprise based on the information surrounding the RtR scheme. Of particular note, sensemaking for both successful and unsuccessful applicants associated becoming a social enterprise with a top down push from central government. A strategic change was necessary in order to cope with the environmental threat of externalisation and the inevitable push towards an open health and social care market (also see Hall et al, 2012). Interestingly, what followed from this push was opportunity as actors believed social enterprise represented a means to improve existing services, a collective opportunity to lead and manage improvements to service delivery, with employees empowered to shape decision making. Becoming a social enterprise was therefore a situated

activity dependent on specific contextual configurations (Jarzabkowski 2004; Whittington 1992). It required external pressures and expectations of the institutional environment and social structures (the policy push) but also an internal cognitive resonance in seeking out the entrepreneurial opportunities associated with social enterprise.

Such sensemaking also highlighted important challenges to realising this vision. The strategic change to becoming more business-like was problematic as the development of this new knowledge was contextually dependent (Tsoukas and Vladimirou 2001). Balancing existing professional requirements and workloads with managerial business like responsibilities created internal conflicts. 'Entrepreneurial readiness' was clearly an issue (Miller and Millar 2011) whereby the move to business practices associated with social enterprise was difficult in the context of existing service delivery. As it stood, such practices did not form part of the 'fields' (Bourdieu 1990) or 'systems' (Giddens 1984) defining current activity.

The implication of these strategic changes also highlighted sensegiving as leaders developed and communicated social enterprise to others in order to gain support and guidance for action (Gioia and Chittipeddi 1991). We find evidence of internal success in communicating the financial and social advantages, engaging in collective decision making, and enabling the freedom to express ideas. However we also find evidence of failures to effectively communicate social enterprise to external audiences: namely existing public sector managers and public sector commissioning organisations. In these contexts, resistance to social enterprise stemmed from it being a new and untested organisational form and a preference for the status quo. Such findings show how the strategic change to social enterprise was challenged by external pressures and expectations of institutional environments by existing governmental agencies and professions (Scott et al 2000; Dacin et al 2002; Greenwood and Hinings 1996). Crucially, it was these external dynamics that determined RtR success. Internal cognitive resonance and sensemaking for strategic change was not enough as 'successful' and 'unsuccessful' narratives were determined by the extent to which leaders were able to gain legitimacy, support and approval from external contexts.

Evidently becoming a social enterprise in health and social care involves the reordering of priorities but also the disruption of established relationships. By providing insights into these 'micro-foundations' (Johnson et al 2003; Whittington 2006) we highlight how such strategic changes is dependent on the extent to which leaders are able to fashion stories that 'concern issues of personal and group identity' (Gardner 1995) but also whether it resonates with existing cultural and historical contexts (Smircich and Stubbart, 1985). These findings have important implications and recommendations for practitioners and policy makers in this area. While the outcomes associated with RtR remain unclear (Miller et al 2012), the experience of RtR shows that greater attention needs to be given to this sensegiving process. The benefits of social enterprise need to be framed as a solution to innovative service delivery but also as a response to the problems associated with existing public sector bureaucracies. If these organisational forms are to continue it will require investment, further policy incentives like the RtR and a cultural acceptance from public sector institutions that social enterprise is a legitimate organisational form.

Concluding remarks

Our article presents a case study of strategic change from public to non-profit social enterprise organisations in England. In this ever increasing area, it makes an important contribution in furthering our understanding of the general and critical issues in the strategic management of social enterprises. Whilst explanations about social enterprise and the third sector have documented important policy developments, changing institutional relationships and discursive shifts (Alcock 2010; Teasdale 2010; Nicholls 2010), we contribute a new dimension to the debate by drawing attention to the individual leaders negotiating and navigating these processes. We contribute a focus on the micro level practices associated with strategic change within this field (Hall et al 2012; Miller et al 2012; Miller et al forthcoming). The article may be susceptible to retrospective bias in its framing of this experience, however, as Whittington (2006) suggests, the essential insight of the practice perspective is to understand what people do, and the relationships outside and within organisations to identify influential and contested practices and to better prepare practitioners for entry into such a strategy.

In conclusion, we suggest that success of any such strategic change to social enterprise will depend not only on the social enterprise organization's ability to implement new structures and processes, but also on the ability to convey the new mission and priorities to the health and social care system (Smircich 1983). We highlight that any further strategic change effort in this area needs to be complemented by a better understanding of sensegiving in terms of communicating and framing the benefits of social enterprise. More attention needs to be paid to the processes that aim to create and legitimate the meaning of strategic change, to create and communicate language and interpretive schemes about social enterprise that resonate with existing institutional values and beliefs within health and social care systems.

The UK and other governments have pledged to extend employee-led social enterprise initiatives across the health and social care sector. These findings appear to suggest optimism for such an organisational form. However, whilst social enterprise may deliver enhanced quality and innovation in health and social care provision, retaining and sustaining the development of such organisations within current institutional contexts may be a challenge. Future research in this area should further investigate the relationship between social enterprise organisations and institutional contexts. Longitudinal analysis and further in-depth ethnographic work is also required that captures the strategic change within this ever expanding policy field, for example exploring the gender dimensions associated with the strategic change process.

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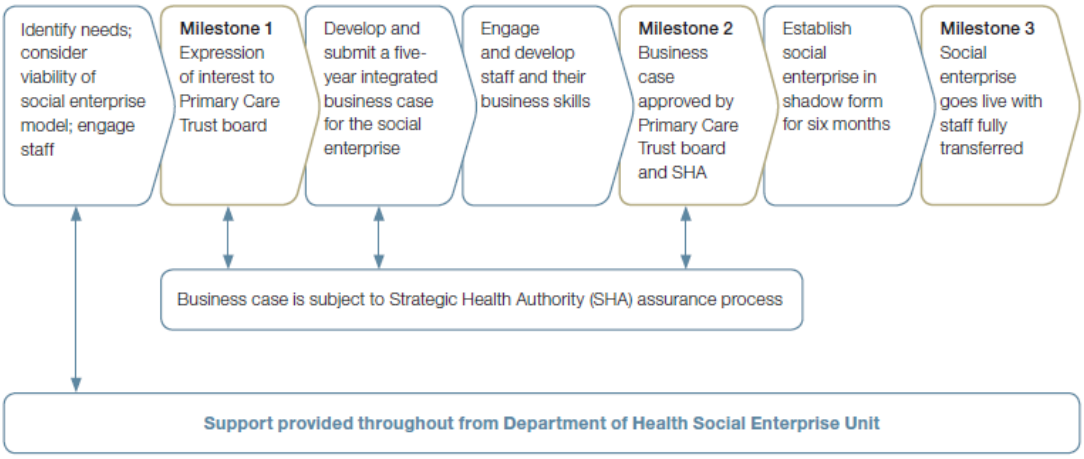
Fig 1. The Right to Request application process

Right to Request process



Source: Department of Health