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Jumped or pushed: what motivates NHS staff to set up a social enterprise?

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Abstract

Purpose – The purpose of this paper is to examine the motivations behind public sector spin outs, focusing on the Right to Request policy, which enabled NHS staff to set up their own social enterprises to deliver healthcare services.

Design/methodology/approach – The paper draws on empirical data gathered from 16 in-depth interviews with individuals who had led a Right to Request proposal.

Findings – Motivations to spin out of the NHS into a social enterprise were often “empathetic” in nature, built around the good of the service for staff and users. Alongside this, some felt “pushed” out of the NHS as a result of government restructuring policy, with social enterprise offering the only hope to survive as an organisation.

Research limitations/implications – The study captures a particular point in time and there may be other perspectives that have not been included.

Social implications – The paper is of use to academics, policy makers and practitioners. It provides an important contribution in thinking about how to motivate public sector staff, especially those from a health profession, to consider spinning out into social enterprises.

Originality/value – The paper is the first to look at the motivations of healthcare spin outs through the Right to Request programme. The findings are related to previous literature on social entrepreneurship within public sector settings.

Introduction

Over recent years English governments have promoted social enterprise and social entrepreneurship as potential solutions to address a range of societal issues and to increase the efficiency and quality of public sector services. This has been particularly prominent within health care as part of wider reform programmes, which sought to progressively introduce a “market ideology” that incorporated private and third sector providers in addition to the publically run NHS. In order to increase the number of social enterprises delivering health care, a number of initiatives have been introduced. These include providing considerable grant and loan funding for new and existing social enterprises, providing contracts to deliver public services and setting up the Right to Request (RtR) scheme in which staff employed within provider arms of English Primary Care Trusts could spin out health services from the NHS as social enterprises.

The RtR has now been superseded by the Right to Provide which applies to the public sector in general and not just community health services. For such initiatives to succeed they must motivate professionals who have generally spent their career as public sector employees to consider working outside of the relative safety of their institutions. This paper presents the perspectives of some of these professionals, focusing on staff that led an application to the RtR programme. It critically examines their motivations to spin out in relation to both the “hooks” presented by central government to encourage staff to consider setting up social enterprises and also in the context of previous research into social entrepreneurship within public sector settings.

The paper begins with a brief overview of healthcare reform with specific attention paid to the RtR policy. It then considers the literature on social entrepreneurship and public sector motivations for setting up social enterprise before presenting our findings of how those leading RtR interpreted their own motivation for

spinning out. It finally assesses the implications of the findings in relation to the literature and future attempts by central governments to encourage public sector staff to “spin out” as social enterprises.

Starting the spin: introducing the “Right to Request”

Between 2007 and 2010 the UK Labour Government introduced a number of reforms within the English National Health Service to stimulate competition and patient choice (see [Allen, 2009](#)). The promotion of social enterprise has formed part of this policy agenda looking to diversify the health and social care market in order to promote innovation, improve quality and increase responsiveness. Although widely used, the term “social enterprise” was not tightly defined. The DTI described them 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” and the Department of Health ([DoH, 2008b](#)) defined them as “businesses established to address a social or environmental need [...] with the coming together of different traditions, including co-operatives, community enterprises, enterprising voluntary organisations and other forms of social business”.

Policy initiatives were introduced to encourage NHS staff to set up social enterprises as a means of “unleashing public sector entrepreneurship” ([DoH, 2006](#), p. 173). They included a Social Enterprise Investment Fund (SEIF) to support new and existing enterprises to extend into the delivery of health care ([DoH, 2009](#)) and a social enterprise Pathfinder Programme which also encouraged existing social enterprises to extend their range of health and social care services and partnerships ([DoH, 2010b](#)).

RtR was established under the Transforming Community Services programme, which required Primary Care Trusts (PCTs) (who were at that point commissioners and providers) to transfer their direct services (provider element) to another organisation ([DoH, 2009](#)) (see [Table I](#) for summary of key terms used within the English NHS). As part of this programme NHS employees within PCTs were given a “Right to Request” to set up new social enterprise organisations to deliver those services. The RtR introduced a process through which staff could submit an “Expression of Interest” to their PCT’s Board and then a series of subsequent milestones through which Boards were assured (or not) that the social enterprise was a worthwhile option as demonstrated through a viable business plan. Staff groups could apply for funding from the Social Enterprise Investment Fund (SEIF) to support the development of their business case and launch the enterprise. Take up of the RtR scheme has varied between different English regions but it was estimated in November 2010 that up to 10 per cent of Community Health Services would be delivered by around 60 social enterprises ([DoH, 2010a](#); [NAO, 2011](#)). This equates to approximately £900 million of service and almost 25,000 staff. It is worth noting though that this was a forecast based on all the planned enterprises going through the process and that in June 2011, ten of the proposed enterprises had dropped out and another 30 were still to come to fruition meaning that the final total could be significantly less ([NAO, 2011](#)).

RtR was initially launched in the final report of the review of English Health Services by Lord Darzi ([DoH, 2008a](#)), who was at the time a consultant surgeon. As one might expect from a review led by a prominent clinician, the review had a strong emphasis on the necessity of health services engaging and empowering their clinical staff in leading improvements in health care quality and productivity. The Department of Health subsequently produced a guide for provider staff within PCTs, which set out, in more detail the RtR process ([DoH, 2008b](#)). Whilst being clear about the key challenges that aspiring entrepreneurs would face, the guide was seeking to encourage staff to at least consider the option and from it we can gain the view of central government as the potential key “hooks” to motivate staff. These are set out as follows:

- improving services through innovation, flexibility and new partnerships;
- putting patients and communities at the centre of services;
- engaging staff with organisations (and vice versa);
- addressing health inequalities and/or unmet needs;
- escaping a cumbersome and bureaucratic system;
- retaining public sector values and brand; and
- delivering wider social and environmental value.

The “hooks” can be divided into three broad themes around improving outcomes for individual patients and broader communities; empowering lay-people and frontline staff to have more influence over services and escaping the shackles of a top-heavy system. It is interesting that the document asserts that “positive” aspects of the public sector will be continued (such as “public sector ethos and values”) but not the aspects

that may be perceived as being “negative” (such as organisational rigidity and lack of creativity). This can be seen as an attempt to persuade staff that what they value about the NHS would not be lost.

The RtR scheme closed in March 2011 but has been replaced by the Right to Provide (RtP) ([DoH, 2011](#)). The main components are the same in that the RtP enables NHS staff to submit initial Expressions of Interest to their Boards and if these are approved funding and support is provided to develop a full business case. However, the groups of staff it applies to are different in reflection of the changing organisational landscape of the NHS in England. The scheme is open to staff who are working within provider Trusts who have not yet achieved Foundation Trust status and so includes not only community services but also acute and mental health services. Staff in Foundation Trusts are not included, as these organisations have been set up as “independent” Public Interest Companies that cannot be instructed by the Department of Health to follow such an initiative. There have also been some changes to the terminology used, with an emphasis on “staff-led enterprises” – this includes “mutuals, co-operatives, co-owned businesses and social enterprises, joint ventures and partnerships”. The motivational “hooks” used to motivate staff are however similar to RtR, with the addition of an emphasis on the personal benefits for the individual staff involved - a “life-changing opportunity” ([DoH, 2011](#)).

Social enterprise and the RtR organisations represent an emerging feature of the English health care landscape. Whilst we find some emerging research in relation to this area ([Baines et al., 2010](#); [Allen, 2009](#); [DoH, 2010b](#)) and specifically on RtR ([Miller and Millar, 2011](#); [NAO, 2011](#); [Addicott, 2011](#)), the role of social enterprise in the context of recent English healthcare reform is relatively underexplored. Whilst it is still too early to see widespread evidence of outcomes, potential emerging benefits of spin outs include more innovative service delivery and efficiency savings ([NAO, 2011](#)). Barriers have however been identified especially around securing funding, as social enterprise spin outs are often dependent on Primary Care Trusts (PCTs) as the dominant source of funding ([NAO, 2011](#)). Concerns have also been expressed about the role of clinicians as entrepreneurs as they may lack confidence when it comes to business skills ([Miller and Millar, 2011](#); [Sankelo and Akerblad, 2008](#)).

Social entrepreneurial motivations: spinning out of the public sector

Traditionally associated with the private and “for profit” sector, the term entrepreneurship has now become more prominent in the literature on public services and the third sector. The concept of social entrepreneurship has hence emerged, which has been defined as “a process of creating value by combining resources in new ways” ([Mair and Marti, 2006](#), p. 37) and is associated with traits such as altruism, passion and a strong ethical fiber ([Bull et al., 2010](#); [Mair and Marti, 2006](#)). [Light \(2008\)](#) has argued that social entrepreneurs can operate in the public sector and as [Teasdale et al. \(2011\)](#) point out, social entrepreneurship in this setting may not be about creating new ventures but leadership in existing organisations. The entrepreneurial motivations of those in the public sector may therefore differ from those working in the private sector.

Whilst motivations for social entrepreneurship have been widely debated, the key motivation usually focuses on the desire to create social value, rather than personal and shareholder wealth as with a commercial or business entrepreneur ([Austin et al., 2006](#)). This is also reflected within the health care sector, with social entrepreneurial motivations reported to be based around increasing access for local people to health care services ([Tillmar, 2009](#)). Social entrepreneurs have also been identified as “team players” and most literature on social and public sector entrepreneurship points to the fact that social entrepreneurial behaviour often encompasses a significant element of teamwork and networking ([Baines et al., 2010](#)). [Scott-Cato et al. \(2008\)](#) put forward the idea of “associative entrepreneurship” and suggest that entrepreneurship is often a collective rather than individual decision undertaken by groups of people. It is often based on mutual values and involves the sharing of skills to achieve the best outcomes.

Whilst social and altruistic motivations tend to drive social entrepreneurial behaviour, there is also a growing recognition that social and commercial entrepreneurial objectives are inter-twined. A “blend” of social and economic objectives has been argued to maximise value ([Emerson, 2003](#)). A spectrum of entrepreneurship may exist, ranging from those with pure social goals to those that are purely profit driven ([Williams, 2007](#)). Social entrepreneurship therefore tends to embrace both the social and economic (although this can vary across the spectrum), and whilst the main focus is usually on social value, economic value creation is often necessary to ensure financial viability ([Mair and Marti, 2006](#)). Financial gain may therefore be one of an expanded set of goals. The financial benefits of social enterprise was also found by [Sesnan \(2001\)](#) in his account of the development of a previous public sector spin out in the UK (Greenwich Leisure). This study emphasises that the decisions regarding setting up the social enterprise were driven by the opportunity to bid for grants not open to the public sector and a reduction in business

tax payments. Therefore, whilst social entrepreneurs may not be motivated by personal financial gain, they may be strongly driven by economic factors.

The idea that social entrepreneurship is based on ethical motives (e.g. [Bull et al., 2010](#)) has also been disputed, as motives can also include less altruistic reasons such as personal fulfilment ([Mair and Marti, 2006](#)). [Morris and Jones \(1999\)](#) suggested that motivations for public sector entrepreneurs are often based around a desire for independence, access to corporate resources and rewards, and an interest in greater power. The desire for power and independence may therefore be strong motivating factors for those setting up social enterprises.

Different entrepreneurial motivations are identified in [Traynor et al. \(2006\)](#) study of entrepreneurship among nurses and midwives. The four motivations were “empathetic” (to improve outcomes for a patient group and/or community through improving service quality and access), “professional” (to provide a greater opportunity to enhance and/or deploy clinical skills), “mercantile” (to have greater independence and autonomy through managing their own business) and “financial” (both as an individual and in terms of maximising the profit for the company). These are all also represented to some degree in the English government “hooks”, although financial is not expressed in terms of personal profit but rather, as suggested above, to generate surpluses to re-invest in services or the wider community ([DoH, 2008b](#)).

A number of studies have looked at the motivations of social or public sector entrepreneurs being as a result of choice (“pull”) or necessity (“push”). “Pull” factors emphasise entrepreneurship as being opportunity driven, with the potential benefits attracting the public sector employee to consider a new venture. Describing these factors as “pull” implies that the employees are passively submitting to this process, whereas in fact a move to set up an external company will require much more active engagement. We are therefore going to refer to them as “jump” factors. These positive “jump” motivations are reflected in much of the literature as being the main entrepreneurial triggers (e.g. [Thompson, 2008](#); [Traynor et al., 2006](#); [Austin et al., 2006](#); [Morris et al., 2006](#)). Implied within this is an element of agency and choice regarding the taking up of an opportunity and may be bottom-up led, being initiated relatively low down in the hierarchy such as by public employees in order to develop a new or existing service ([Windrum, 2008](#)). “Jump” factors may include a range of benefits for the entrepreneur, the service or its users.

Alternatively, “push” motivations occur when the element of choice is taken away and instead the enterprise is developed out of necessity. This for example may be in response to a negative change in the external or internal environment ([Morris et al., 2006](#)). Such motivations may be top-down led which tend to be initiated high in the hierarchy such as by ministers and often occur with changes in governance frameworks ([Windrum, 2008](#)). Whilst there are suggestions within the literature that commercial entrepreneurs are more likely to “jump” whilst social entrepreneurs tend to be pushed ([Williams and Nadin, 2011](#)), there is no empirical evidence that this is the case ([Williams, 2007](#)).

This paper looks at the motivations of NHS staff to “spin out” into social enterprises within the context of literature on social entrepreneurship. We focus on the perspective of those leading a RtR spin out, looking at where motivations arose from, in particular if they were born out of choice (“jump”) or necessity (“push”). The motivations of the individuals leading the RtR are also considered, especially in terms of the extent to which the spin out was driven by social/altruistic factors, or if financial or personal factors played a part. We finally look at the extent to which these people worked as individuals or team players.

Methodology

To understand what motivated the aspiring entrepreneurs, we took an overarching interpretive approach exploring how the “meaning” of the RtR was understood by the people who had led a RtR proposal and how this resulted in the motivation to spin out ([Yanow and Schwartz Shea, 2006](#)). To access this experience and sensemaking in relation to the RtR policy, the research employed semi-structured conversational interviews with actors who we identified as being centrally involved in the RtR process ($n=16$). They provided a “case” of RtR activity and were selected on the basis of furthering our understanding and learning about the policy. These individuals were obtained using a purposive sample of individuals who had led RtRs within their organisation. This included those that were successful ($n=6$) and unsuccessful ($n=10$) in launching their enterprise.

The professional background of these individuals was 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. These actors also operated across a range of organisational contexts in which

the RtR process was happening. This included those that were leading the spin out of large scale whole community provider organisations delivering a range of different primary and community services, and smaller scale services responding to specific patient groups (e.g. substance misuse services) and particular user groups (e.g. children's services). The sample of individuals was geographically dispersed across different regions in England.

The research did not choose a theoretical model a priori but, instead, built one from the data. As with [Feldman et al. \(2004\)](#), our insights were grounded in theory without testing any predetermined set of hypotheses about what we would find. What emerged from the interviews was a variety of interpretations about the RtR policy. Data analysis focused on the stories these actors employed to make sense of the motivations surrounding RtR ([Weick, 1995](#)). This process centred on identifying the various “story lines” defining points about the motivations associated with RtR ([Feldman et al., 2004](#)). Coding the data then grouped these passages of text into narrative themes. As highlighted below, these centred on how actors understood the policy drive, the decision to spin out and experiences of working with others during the RtR process ([Strauss and Corbin, 1990](#); [Miles and Huberman, 1994](#)).

Findings

The motivations of the interviewed social entrepreneurs to spin out of the NHS are now discussed. What emerged from the stories about the RtR policy were three narrative themes:

1. a narrative that centred on the RtR policy drive, focusing in particular on the extent to which choice was exercised in the decision to spin out;
2. the motivations for entrepreneurship by the individual(s) leading the RtR; and
3. the extent to which entrepreneurship was an individual or collective/team venture.

“Pushed or jumped?”

We looked at the extent to which staff were pushed or jumped from the NHS into social enterprise. Some participants referred to “push factors”, which arose as a result of the real or perceived threat that a change in the external environment would have on their service and staff. The policy directive that “the PCT must divest themselves of provider services” was prominent for these respondents and unless they transferred into a social enterprise they felt that the service was at the “end of the road”, by going out to open tender, the service being dissolved or transferred to a Foundation Trust whose emphasis was a different type of service:

Well we sort of saw the writing on the wall if you like with how the NHS was changing.

We were going to be hawked off to the cheapest provider.

For these respondents, a major driver for setting up an enterprise was not so much about aspirations or improvement but about retaining a service in a form that they felt confident in. Service preservation was the key driver. This is evidence of a top-down led venture, with a limited amount of choice being exercised by these respondents as changes within health policy “pushed” some them into forming social enterprises. As one respondent expressed it, “[...] there wasn't anywhere else to go”.

In relation to “jump”, the motivations were mainly focused around taking control of the service, becoming independent from the NHS and “doing it better”. Respondents referred to being part of the NHS as “being chained” and spinning out was considered to be “breaking free”. Gaining independence was a key driver, with opportunities to design and deliver their own service extremely important:

We have broken free out of our chains. No, that's probably a bit dramatic but I think there's a much stronger sense of ownership with us and the staff.

There was a strong desire to do things differently away from the constraints of the NHS, which was also indicative of a rejection of NHS bureaucracy in favour of organisational forms that promoted greater innovation:

I would prefer to belong to a place which had fewer people in it and was less bureaucratic.

Releasing innovation and developing the chance to develop different types of services that might not fit in the NHS.

Furthermore, despite social enterprise being based on a private ownership model, many participants were also found to reject the principles of private health services. What emerged here was the goal to do it better than both the NHS and private health services:

Private companies will make a profit for their shareholders and the banks and it won't be for the community.

These “jump” motivations were thus driven by new opportunities. This is evidence of a bottom-up led innovation, with policy directives being less influential. Although policy directives created the landscape for spinning out of the NHS, these participants could be seen as having stronger entrepreneurial characteristics than push motivations, with an emphasis on innovation and a desire for change lying at the heart of the decision.

For most of the participants though there was a balance between the “push” and “jump” factors – i.e. they were concerned about the likely future organisational form of their service and were looking for an alternative option, but equally could see the potential benefits of social enterprise. The “push” factors can be further subdivided in terms of the perception and role played by their NHS organisation. For some participants, their organisation was supportive and indeed may have initially suggested the option, so can be viewed as giving a “friendly” push. For others the “push” was more hostile as it resulted from the RtR leader(s) not agreeing with the future form that their current organisation were favouring. Somewhat unsurprisingly those RtR groups with a supportive push were more likely to be successful than those whose proposal was contrary to the views of their organisation.

“Entrepreneurial aspirations”

A variety of motivations emerged from the stories of the individuals leading the RtR process within each organisation. These are based around the benefits gained as a result of becoming a social enterprise. First, financial reasons did emerge as a motivating factor for setting up a social enterprise; however, this was not in the sense of generating personal income and profit maximisation. Instead money was mentioned within the context of improving the organisation, reinvesting profits, making efficiency savings or bidding for new contracts:

There is lots of money that we can't bid for at present that we would be eligible for [as a social enterprise].

This motivation therefore supports social enterprise as being a vehicle to generate surpluses that are re-invested for the good of the service, service users and wider community:

We are looking at making surplus, we hope, will be reinvested back into developing services and inter-training and development of our staff. That's why we're a social enterprise.

Your fundamental reason for being there isn't to make pots of money, or pots of money for shareholders – you're there to make a difference.

This contrasts with their perception of how “profits” or “surpluses” would be dealt with in the private sector (where it would be passed to shareholders) or the NHS (where it would be used to meet overspends and pressures elsewhere in the organisation rather than kept within the service). The social enterprise ethos and values were therefore at the forefront of the RtRs. The benefits to staff and service users of being a social enterprise were frequently mentioned by all respondents. This therefore highlights the prominence of improved outcomes for service users in the reasons for setting up the social enterprise. This includes improving patient choice and access to the service:

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 we do.

It's about giving power to staff and sharing this power with people who use the service – the people that pay your wages.

The empowerment of staff also featured as a reason for spinning out. Personal empowerment and ambition were also mentioned by those leading the RtR. For some, the RtR gave them the chance to fulfil their dream of running a business and empowered them through the ability to make decisions and take new opportunities:

You're a bit more master of your own destiny in a way and you can run things how you want them to be run.

Again, on a personal level, some respondents felt that setting up the social enterprise created an opportunity for them to develop their own skills and expertise. Undertaking the RtR was considered to be a new challenge for many respondents, enabling them to develop professionally and learn new skills:

I've been a nurse, midwife, health visitor, manager, done Sure Start and lots of projects and working on this project has been probably one of the best for me professionally and I thought, "Well, I should be retired really," but it's just given me a new lease of life because I want to see it through.

Some respondents therefore focused on the development of their management skills; however, others were more concerned with their clinical skills. Leaving the NHS enabled some respondents to become better clinicians and work in a more effective way:

We were not really functioning as Clinical Psychologists, as we thought we should be, that we were not being able to work in the way that we were trained to work in. And we both felt that this [R2R] might be an opportunity to work the way we should be working, be as effective as we thought we could be.

There were therefore a range of motivations for entrepreneurship at both a collective and individual level. The following section therefore looks at the extent to which motivations and decisions to go through RtR were driven by the individual entrepreneur or the team.

"Collective entrepreneurship"

As the previous discussion indicates, motivations to spin out were based on both personal aspirations, as well as "the good of the service". Whilst, setting up a social enterprise did tend to be driven by one (or two) individuals who took leadership of the project, this was only undertaken with support from the entire staff team:

I really believed it was the right thing to do, and I could speak to staff, I think, with some real conviction about this is a really good thing for us to do.

Therefore, the overarching discourse within the interviews was one of teamwork and the empowerment of the whole staff group. Decisions regarding the social enterprise and service were made collectively indicating a strong "We" rather than "I" culture:

And being a social enterprise we would be in control of our destinies, the whole thing about staff ownership was very attractive.

Teamwork featured very heavily in the development of the social enterprise and only with support from the entire staff group would the RtR go ahead. As a result of teamwork and collective goals, it was felt that the resulting social enterprises would have lower rates of staff absenteeism, enhanced staff motivation and therefore ultimately an improved service:

More freedom [...] not just for myself and [other] executive director but also the team. I feel they have a lot more freedom to bring their ideas to us [...] It is about team effort, it's never about individual people.

Whilst personal desires and aspirations were often part of the entrepreneurial motivations, these aspirations tended to be constructed as part of a wider team of staff. Therefore, despite leading the RtR, the narratives of most interviewees referred to the social enterprise as being a team venture. Entrepreneurship was therefore not about the aims and desires of one person, but of a wider group of people.

Discussion

The purpose of this paper has been to examine the motivations behind public sector spin outs, focusing on the RtR policy, which enabled NHS staff to set up their own social enterprises to deliver healthcare services.

Our research identified a variety of different motivations associated with spinning out. Some of our respondents did show strong entrepreneurial characteristics that were “personally” orientated ([Mair and Marti, 2006](#)). The emphasis was on personal development, enabling them to lead innovation in new service delivery and “do things differently” away from the NHS structures and boundaries that they considered to be a constraint. Similarly, “professional” aspirations ([Traynor et al., 2006](#); [Tillmar, 2009](#)) arose in the way that the RtR policy acted as an opportunity for empowerment through a new business opportunity. This enabled the development of clinical and/or management skills. Many therefore felt that the RtR provided opportunities for greater independence in the way in which services were managed.

Whilst these motivating factors appeared to be crucial, what also emerged as a strong theme from the research were motivations driven by “empathetic” aspirations ([Traynor et al., 2006](#)) that were crucially built around teamwork. Entrepreneurs supported the general social enterprise ethos of the social wellbeing and the “good of the service”. This meant that a focus on outcomes for users and staff were often at the forefront of decisions to spin out. As a result, whilst our interviewees took leadership of the RtR either by themselves or with a handful of colleagues, they were committed to doing so with the support of the whole or at least the majority of the whole staff group. In some ways this was a practical requirement (as the policy required the support of staff to be evidenced) but it appears that they would in any case have been committed to a collective ethos, rather than the desires of one (or two) individuals (e.g. [Baines et al., 2010](#)). It will be interesting to see if this collective approach is maintained in the running of the new organisations and the extent to which “mutual principles” are embedded within the governance and decision making processes.

The RtR policy was promoted by government as a “development opportunity” built around the “hooks” we identified in [Table I](#). These hooks appear to have struck a chord as we can see the three themes of “improving outcomes”, “empowering staff and clinicians” and “escaping” from the current system all echoed through the stories of those leading the RtR schemes. This positive decision to “jump” into a social enterprise was generally matched by a feeling of being “pushed” out of the NHS in generally, although not exclusively, a hostile manner. Rather than a bottom-up policy, the experience was felt by many as a top down intervention (e.g. [Windrum, 2008](#)). This motivation, i.e. “a social enterprise or else”, was understandably not part of the Department of Health literature or publicity, but was a strong influence for many of those interviewed. This echoes the findings of a recent Kings Fund report ([Addicott, 2011](#)), which reported that the growth of social enterprise has largely arisen as a reaction to government re-structuring policies. Whilst many of the participants in our study felt “pushed” by their employing organisations, most were also keen to “jump”, and in many ways this is an ideal scenario if it means that motivations of the authorising environment and the staff group wanting change are aligned. Previous work on RtR showed that organisations in which staff were keen but senior management were resistant or apathetic, were far less likely to succeed ([Miller and Millar, 2011](#)). For those who were unsuccessful, it could be said that they were “pushed”, also tried to “jump” but were ultimately “slapped” back by their organisation (reflecting the painful experience and emotional “bruising” this has involved for many of them).

In policy terms our findings suggest that a narrative that stresses the “positive” benefits of spinning out combined with a “threat” of what will happen if this option is not pursued may be the most effective in “persuading” public sector staff to take up the social enterprise option. However, there also needs to be support from local decision makers if staff groups are going to be able to act on these motivations. Although too early to look at the outcomes of RtR social enterprises, it will be interesting to see if there is

any connection between motivations to spin out and the “entrepreneurial” nature of the enterprises that are created – will those who had to fight hardest come out of the experience more ready to compete in a pressured market than those who were given an easier exit? This certainly presents opportunities for future research in this area, along with the exploration of the difference that “spinning out” has made to the delivery of services and long-term engagement of staff and patients.

Conclusion

Social enterprise is an emerging feature on the English health and social care policy landscape. The RtR programme was established to enable professionals to spin out of the NHS. The purpose of this paper has been to capture the motivations of those entrepreneurs leading the RtR process. It has found that many of these entrepreneurs suggested a jump towards social enterprise as a potential to innovate and be responsive to service users. Interestingly, what also emerged was a desire for a “collective jump”; it would be a team effort rather than an individualist pursuit. Alongside this jump towards social enterprise, our research also found strong evidence of a “push”. The policy context of an increasing competition and choice in primary and community services meant that for some it was a case of “sink or swim”. Entrepreneurs described how they were pushed towards social enterprise in order to survive as an organisation.

Evidently our study captures a particular point in time and there may indeed be other perspectives we have not included. However, it provides an important contribution in thinking about how to motivate public sector staff and in particular those from a health profession to consider setting up a social enterprises. This may also have implications for the future of the Right to provide programme, in terms of the motivations and experience of entrepreneurs. Our findings indicate that positive messages that speak to staffs' professional values, emphasise the benefits for end-recipients and enable collective action will have a motivating influence. However, we also suggest that these positive messages will have the most impact when combined with the firm “push” of a more negative fate.

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|---------------------------|--|---|
| Primary Care Trusts | Primary Care Trusts (PCTs) were the bodies largely responsible for the “commissioning” of NHS funded healthcare services for a defined geographic population. “Commissioning” was seen as a cyclical process incorporating the assessment of the population’s health needs, prioritisation of the use of available resources, procurement of services from appropriate providers, and monitoring the delivery of contractual requirements. Prior to April 2011 PCTs also delivered a range of community health services. PCTs are currently being replaced by Clinical Commissioning Groups led by General Practitioners | |
| NHS Trusts | The main organisational form through which NHS acute (i.e. hospital) and mental health care has been provided since the 1990s. NHS Trusts are public bodies accountable to the Secretary of State which are run by Boards of Non-Executive and Executive Members (with the Chair of the Board being a Non-Executive) | |
| Foundation Trusts | Foundation Trusts’ Boards are accountable not to the Secretary of State but to Governors comprising elected staff and patients and representatives from key partner agencies. Introduced in 2003, they take on the new organisation form of “public benefit corporations” and are expected to have a more “business-like approach” than NHS Trusts. The current government expects the majority of Trusts to become Foundation Trusts by April 2014 | |
| Community Health Services | Community Health Services are those services delivered in the person’s own home or in a community setting such as a local health clinic, school or care home. Community Health Services commonly include community nursing services, health visiting, physiotherapy, and speech and language therapy but in some areas also incorporate more specialist services or generic services targeted at particular groups within the population such as the homeless or those in prison | |
| Primary care | Primary care services are those delivered by general practitioners (and staff based within their practices) and community based pharmacies, dentists and optometrists | Table I. Key terms from English NHS at time of Right to Request |

Table I Key terms from English NHS at time of Right to Request

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