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On the character of the new entrepreneurial NHS in England

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On the character of the new entrepreneurial NHS in England: reforming health care from within?

Running head: The new entrepreneurial NHS

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Accepted Article

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Abstract

Recent health care reforms in England, combined with financial austerity, have accelerated both corporatization and commercialization in the English National Health Service (NHS) and this has encouraged greater public sector entrepreneurialism (PSE). We advance this argument by examining the meaning and experience of corporatization in this sector, illustrating our argument with qualitative data from a specialist hospital at the forefront of this trend. We demonstrate how the policy and practice of corporatization is entangled with increased commercialism and how this shapes more entrepreneurial conduct from staff. Framed in terms of the recursive relationship between organizational dynamics and individual behaviours, we focus empirically upon the shifting epistemic boundaries associated with increased corporatization, describing the dissonant effects of these shifts upon individuals, their attempts to compartmentalize, and the ethical dilemmas that result. Through this case we draw conclusions about the emerging impact of corporatization, commercialization, and public sector entrepreneurialism across public services.

Accepted Article

Introduction

The corporatization of public services is an international, cross-sectoral trend that has gathered pace in recent years (Clifton & Diaz-Fuentes, 2018; Grossi & Reichard, 2008; Voorn *et al.,* 2018). Corporatization in the public sector involves the transformation of governmental departments and units into semi-autonomous organizations, subject to private commercial law with independent revenues and managerial independence, but still under at least partial state control (Andrews *et al.,* 2020). This shift exposes public service delivery to greater competition with the aim of driving efficiency (Lindlbauer *et al.,* 2015) and establishing private-sector management practices as standard (Bourdeaux, 2008). Corporatization therefore represents an example of systemic or public entrepreneurship (Bernier & Hafsi, 2007) insofar as it 'shifts control of service delivery from politicians and bureaucrats to professional managers who are motivated to find innovative service delivery solutions' (Andrews *et al*., 2020, p. 485). The reach of corporatization has extended into key public services (including health care) across Europe, the USA and other developed economies (Braithwaite *et al.,* 2011; Ferry, Andrews *et al.,* 2018). In this paper, we explore how such a shift takes place through the conduct of individual middle managers within a public hospital in the vanguard of corporatization and commercialization. Our focus therefore is upon the manner in which corporatization and associated entrepreneurial behaviour is understood, contested, and enacted within state-owned corporate entities (as opposed to privately owned), and the effect upon the frontline of public service delivery.

The roots of European public service corporatization can be found in the series of reforms initiated from the late 1970s onwards, often referred to collectively as New Public Management (NPM), which sought to rationalize public spending by placing pressure on public services to operate in more 'business-like' ways (Hood, 1991), creating new executive and managerial roles and introducing an array of new performance management and auditing practices. Although it is questionable in the short term how effective a form of rationalization these reforms were (Harrison *et al.,* 1992), viewed over a longer time period, they prepared the ground upon which such an agenda could be pursued more emphatically (Ongaro & Ferlie, 2020). Change has been accelerated by the pressures produced by the

radical cost containment measures introduced in the wake of the 2007-08 financial crisis in the UK and elsewhere (Exworthy *et al.,* 2016). This has heralded a distinct modality of corporatization in an uneasy alliance with competition and commercialization, which has driven a more entrepreneurial approach into the workings of public organizations. In the English NHS, such activity ranges from maximizing revenue from ancillary services such as car-parking (www.theguardian.com/society/2016/oct/14/car-parking-at-hospitals-in-england-rises-average-15-since-2014) through to commercial land sales (www.hsj.co.uk/finance-and-efficiency/exclusive-half-of-land-proceeds-go-into-revenue-despite-reinvestment-pledge/7023770.article) and joint-venture activity (www.hcahealthcare.co.uk/news/press-releases/new-65-million-pound-specialist-hospital-facility-planned-for-birmingham), and even investing in music festivals (www.hsj.co.uk/finance-and-efficiency/trust-lost-more-than-360k-over-cancelled-music-festival/7030504.article). As an illustration, the Royal Marsden hospital which, in 2021, opened the 'first state-run cancer treatment centre in the world-renowned medical district' of London, as a form of direct competition with the private sector (Plimmer, 2021). The COVID-19 pandemic has forced the NHS and its myriad of organizations to address their revenue streams, despite an increase in NHS funding (Charlesworth, 2021), further encouraging organizations to pursue commercial opportunities.

Although corporatization does not necessarily entail commercialization, corporatization certainly enables commercialization by repositioning public service organizations in a competitive setting. Commercialization is accelerated by the introduction of market mechanisms similar to those introduced in the UK in the 1980s and 1990s; however, where these were originally concerned with cost-containment, their contemporary use encourages revenue-seeking behaviour among managers (Waring & Bishop, 2013). At the same time, corporatization has encouraged market entry by a more diverse range of service provider organizations (Gore *et al.,* 2018), with a marked increase in private provision and a shift towards more transactional service provision based on contracts and tariffs (Sheaff *et al*., 2019). This shift has also been accompanied by a retreat by the state in some areas of health service provision, such that there has been an increase in out-of-pocket expenditure; in the UK, this represents 16.7% of all health expenditure

(https://data.worldbank.org/indicator/SH.XPD.OOPC.CH.ZS). Together these changes have produced a complex, 'hybrid' system in the NHS (Gore *et al.,* 2020; Thynne & Wettenhall, 2004) in which quasi-corporate organizations interact within a quasi-market comprising both public and private bodies (Exworthy *et al.,* 1999), with several semi-autonomous and arms-length bodies outside central government providing strategic direction and oversight (Hammond *et al*., 2019). Within this hybrid system, the evolution of corporatization over the last 20-30 years has necessitated more entrepreneurial behaviours across public services (e.g. Currie *et al.,* 2008). The pressures of austerity in the last decade have driven a more intensified form of public sector entrepreneurialism (PSE) as financial survival is increasingly dependent on a degree of successful commercialization and revenue-seeking behaviours (Sheaff *et al*., 2019). Pursuit of income generating opportunities not only bolsters financial stability to enhance core public service delivery but also, it is argued, enables greater innovation and service responsiveness as PSE becomes normalized through the organization (De Vries *et al.,* 2016). Nevertheless, there are less positive consequences of this shift in managerial conduct, including the erosion of solidarity and public ethos, the elevation of profit motives and the shift away from service provision as the core purpose of public organizations (du Gay, 1993; du Gay & Vikkelsø, 2016).

Managers and staff in such settings are thus increasingly likely to be confronted with challenges to their professional identity as public servants and exposed to ethical tensions as they navigate between entrepreneurial and public service expectations in the performance of their role (c.f. Bresnen *et al.,* 2019; Croft *et al.,* 2015). It is with these challenges, and the responses of those within healthcare organizations in particular, that this paper is concerned. Although the idea of PSE within healthcare is certainly not new (e.g. Currie *et al*. 2008), to date, there has been comparatively little research undertaken that examines how PSE is experienced, enacted and contested by managers and staff involved in its implementation in healthcare organizations (Hyde & Exworthy, 2016; Hyde *et al.,* 2016) and how this affects their core mission: the delivery of patient care (Park *et al.,* 2021).

In order to examine the impact of corporatization on NHS organizations and staff engaged in commercial activities, this paper builds upon an in-depth case study which traces the experience of

Accepted Article

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PSE in a prominent 'corporatized' public sector healthcare organization in the English NHS between the years 2012-2017. The hospital was selected as it had taken advantage of corporatization to encourage income generation activities, including a significant charitable arm and commercial partnerships with private sector organizations. As a nationally reputed hospital with a track record of being in the vanguard of commercialization, it represents a critical or revelatory case study of commercialization within the sector (Gerring, 2006). It thus offers insights into how public service employees encounter commercialization in a corporatized organization, the challenges experienced in embracing PSE, and the coping and adaptive strategies adopted. Consequently, these insights have analytical generalizability (Exworthy *et al.,* 2011; Yin, 2017) in helping understand the effects of corporatization and commercialization upon the entrepreneurial conduct of public service managers.

Corporatization and commercialization within the English NHS

The roots of both corporatization and commercialization within the NHS can be traced back to the advent of NPM in the late 1970s (Hood, 1991), although prior to the formation of the NHS, entrepreneurial approaches were regularly needed to secure hospital funding (Gorsky *et al.,* 2005). Successive political initiatives over decades (see Table 1) have produced a complex and conflicted policy landscape with discourses and practices associated with both competition and collaboration, centralization and devolution and other forms of hybrid governance (See Figure 1). In practice, the shifts depicted in Figure 1 have resulted in ambiguity in governance at strategic and operational levels, which has produced increasing heterogeneity at the practice level as different organizational and spatial boundaries shift (Gore *et al*., 2018; Gore *et al*., 2020).

TABLE 1 ABOUT HERE

FIGURE 1 ABOUT HERE

A key step in the corporatization of the English NHS was the transformation of many NHS organizations into 'Foundation Trusts' (FTs) from 2000 onwards. FTs were established as non-profit, public benefit corporations but this status gave them the opportunity, inter alia, to raise their own financial capital, vary national pay rates, and retain savings. In the 2000s, FTs did not exercise their

Accepted Article

freedoms fully; whilst many retained savings, many did not vary their pay rates for fear of being seen to poach other local staff and much of the centralized regime remained intact. As a result, there was initially a lack of risk-taking and limited innovation (Exworthy *et al.,* 2011).

However, the combination of changes implemented through the Health and Social Care Act (2012; HSCA), and a decade of austerity policies generated renewed impetus for exploring the freedoms given to FTs, particularly by those organizations in a position to exploit commercial opportunities. The HSCA enshrined competitive and commercial behaviour in law and made anti-competitive behaviours subject to increased regulation. At the same time, regulators were charged with encouraging cooperation, resulting in considerable ambiguity and local autonomy regarding the balance of competition and collaboration (Osipovic *et al.,* 2016). The act also abolished caps on the commercial income of FTs, which henceforth just had to keep a majority of income from public sources – what became known as the `49% cap' (Exworthy *et al.,* 2016). At the same time, UK public services have also endured an unprecedented period of (financial) austerity with static or declining budgets while demands upon services have been higher than ever (Lafond *et al.,* 2016). In practice, this has been manifested in a tightening of the formula for reimbursement to NHS trusts; under a national tariff in the English NHS, the government has reimbursed organizations £760 (in 2017-18) for care that cost them £1,000 (in 2009-10) (Gainsbury, 2017). Faced with this shortfall, exploring routes towards alternative commercial revenue has been presented as the only solution for organizations (Exworthy & Lafond, 2021); for example, NHS Improvement, in 2018, reporting 'increased opportunities for income generation from the commercialization of certain "noncore" NHS Functions' (NHS Improvement, 2018). These pressures and 'opportunities' necessitate a more entrepreneurial orientation among public sector managers. Analysis of documentation from organizations in the vanguard of this development highlights the low risk of commercial activities to their (clinical and financial) reputation (Exworthy *et al*., 2016). Such documentation does not, however, consider the impact of commercialism upon staff, or upon wider considerations such as organizational ethos.

Public Sector Entrepreneurialism

PSE has been a 'leitmotif' of NPM since the 1980s (Lunt *et al.,* 2015), with public agencies encouraged to mimic private sector approaches, and has been broadly facilitated by corporatization, as Boyett notes (1996: 49): 'Entrepreneurship occurs in the public sector where there is an uncertain environment, a devolution of power, and at the same time re-allocation of resource ownership, to unit management level'.

Currie *et al*. (2008) argue that PSE comprises three inter-related `agencies': stakeholder, political and entrepreneurial:

> *'The public sector entrepreneur identifies market opportunities within the political landscape, optimizes the performance-enhancing potential of innovation for the public sector organization, and carries stakeholders in a way that both permits risk and recognizes the stewardship of public sector resources' (p.987)*

Along with the heroism implicit in this definition of PSE, there is a palpable sense of the modernization agenda of which this wave of PSE was a part, valuing opportunism, optimization, and innovation (Waring & Bishop, 2011). Yet there is also a suggestion of its potentially dysfunctional consequences – the tensions between 'risk' and 'stewardship' signifying blurred boundaries between what is `public' and `private', what is `public interest' and `self-interest', and what is necessary to deliver public services within constrained finances. As these institutionalized boundaries become disrupted, there are associated shifts in the framing of expected and legitimate conduct at the level of public service delivery (Gore *et al*., 2018).

There is some evidence of commercialization being connected with the transfer of staff into or out of the NHS (Currie *et al*., 2008; Waring, 2015). The presumption however that commercialization is achieved simply through the hiring of those who embody commercial or entrepreneurial values, skills and knowledge understates the importance of context in shaping how those values, skills and knowledge are (or can be) directly applied. Furthermore, whilst some individuals have undoubtedly moved in both directions, most NHS staff have remained working in the NHS (Macfarlane *et al.,* 2011), though many doctors straddle both sectors – an affordance of the original NHS contract

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(Timmins, 1995). Consequently, the influence of the private sector has been felt much more through the spread of commercial practices within the NHS and this, in turn, has continued to impact upon the role expectations and identity of NHS staff (Waring, 2015) and their sense of legitimacy (Hodgson *et al.,* 2015).

In this context, how individuals in operational roles engage with and enact PSE thus becomes a key empirical question. Shifting institutional boundaries bring to light alternative and potentially conflicting ways of knowing and doing in organizations (Knorr-Cetina, 2009) and while the 'agencies' of PSE described by Currie *et al*. (2008) might be available to those with both strategic foresight and executive authority, for those engaged more directly in service provision, shifting epistemic boundaries and the conflicting expectations they generate create considerable tensions and challenges.

A second key empirical question arises about the resultant impact of PSE upon individuals' identity work (Bresnen *et al*., 2019; Croft *et al*., 2015; McGivern *et al.,* 2015). The NHS (and its staff) has traditionally been seen as a repository for values and practices of altruism and vocation (Klein, 2010), and it is commonly held that NHS staff are guided by intrinsic motivations. The altruistic basis to clinical work is a commonly cited aspect of public ethos, shaped by professional norms and values (Exworthy *et al*., 2016, p. 84), and this might equally apply to non-clinical staff (Le Grand, 1997). Thus in principle, the introduction of a commercial ethos may present a challenge to the identity of the public servant in the NHS. However, as outlined above, the history of markets and managerialism in the NHS has never been uniform or unidirectional, and this has resulted in individuals internalizing 'hybridity' (Bresnen *et al*., 2019; Gore *et al*., 2020). This generates an empirical question about the strategies adopted by staff to reconcile the conflicting tensions resulting from the interconnection of divergent logics (Bailey *et al.,* 2020; Martin *et al.,* 2020). As the idea of divergent logics suggests, there is disagreement over the nature and character of commercialization and corporatization in the public sector. This underscores our empirical approach which was designed to trace the ways in which these ideas are expressed and take shape within locally situated practices, and how this shifts over time.

Accepted Article

Closely related to this issue of reconciliation, a third key empirical question relates to the ethical concerns that result from acting entrepreneurially in a context infused with a public service ethos. The organization of the NHS is replete with examples of ethical dilemmas for individuals and organizations, often situated by the need to reduce health spending and, accordingly, rationalize decision making, which has been one of the principal driving forces for top-down NHS reorganizations since the 1970s (Exworthy, *et al*., 2016; Harrison *et al*., 1992). The argument typically presented in defence of commercialization is that such activities unlock additional revenue streams which benefit public delivery of care, which thereby obviates any intrinsic ethical concerns. However, we argue that this contains an assumption that PSE is in some way value-free and that the pursuit of efficient or enterprising public services is ethically neutral. This can be called into question when considering the effects of PSE in re-directing organizational interests away from the delivery of services to patients.

Methods & Settings

The research upon which this paper is based, took place at two different time periods: an initial study from 2011-2014 and a follow-up conducted in 2016-2017, and is thus concerned with the period when the HSCA was enacted and implemented across the English NHS. The initial study was funded by the NIHR Health Services and Delivery Research programme (Bresnen *et al.,* 2014), and examined the hybrid nature of NHS middle managers' knowledge, identities and practices. The research adopted a multiple case study approach (Eisenhardt & Graebner, 2007) with the aim of developing theory about the contested practice of management and leadership within contemporary shifts associated with PSE described above. Interviews and observations were conducted in three types of NHS organization (acute, community, specialist), also taking into account the diversity of occupational and professional orientations and backgrounds of managers across three broad domains (clinical, general, functional). Conceptually driven by the understanding that knowledge develops in communities and networks of practice, the research explored how this occurred across a diverse sample of managers, and how different career paths and aspirations interacted over time with shifting and contested discourses of what it means to be an NHS 'manager' (Bresnen *et al.,* 2017a).

Accepted Article

The research was based around formal, semi-structured interviews with middle to senior level managers in each organization, augmented by observations of meetings and other events. Middle managers were defined as individuals at least one level above service management and at least one level below board. Semi-structured interviews were conducted by two members of the research team. A total of 68 formal interviews were conducted, transcribed, and analysed, and have been written up in several publications to date (Bresnen *et al*., 2019; Bresnen *et al*., 2017a; Bresnen *et al.,* 2017b; Bresnen *et al.,* 2015). Interviews adopted a broad schedule to explore the shifting meanings and experiences of management, leadership, and professionalism in the context of radical political and organizational reform. Aligning with this exploratory approach, initial coding organized data into five broad themes: career, knowledge, relationships, organization, and change. Detailed, inductive coding was then undertaken collectively between research team members, involving ongoing discussions, and refinement of the emerging coding framework. A third stage involved creating different groupings of codes in order to explore prevalent themes in more analytical detail. The present analysis drew upon a grouping of codes that included; commercial activities and orientations; charity, research, branding, public vs. private, growth and finance.

The follow-up study began in 2016 with the aim of building upon the findings of the initial study with a particular focus on commercial activities and orientations, focusing on one of the sites from the initial study (the specialist trust; given the pseudonym here of St. Tony's). This made for a within-case analysis of a trust that was not typical of other NHS hospitals. The purpose of a 'revelatory' case such as this is to develop a deeper understanding of a complex phenomenon according to the manner in which it is situated in local systems and practices (Yin, 2017). The present case therefore examines the situated enactment of corporate and commercial values by middle managers in a relatively commercialized NHS setting. We do not claim that our data presents a more general picture of commercialization in NHS management, rather we argue that the multiple meanings and practices associated with commercialization make such generalization problematic. Instead, our purpose it to show how the broad and long-term policy trend towards greater corporatization and commercialism can be traced through at the meso and micro levels (Gerring, 2006), and the tensions and challenges

Accepted Article

that result for organizations and individuals. Contemporary events serve to reinforce the wider relevance of our argument, as the fiscal constraints which have further driven the political emphasis upon entrepreneurialism have been reinvigorated in the context of the economic recovery from the COVID-19 pandemic and the disruptions to trade following Britain's exit from the European Union (Inman, 2021).

At the time of the first study, St. Tony's was relatively well positioned to take advantage of PSE and well-insulated against austerity spending. Nevertheless, commercialism was not universally popular among managers, and tensions were surfaced during interviews, which we explore further below. Our aim in returning to the site was to see how these emergent opportunities and tensions had developed over time, attending to the three empirical questions listed above; in what ways does NHS commercialism challenge established epistemic boundaries; how do individuals attempt to navigate the tensions that arise from their enaction of PSE; and what ethical dilemmas result from this attempt?

To this end, interview participants from the initial study were contacted and invited to take part in a further interview to revisit the findings of the initial study. Six audio-recorded interviews were conducted in the follow-up which, combined with initial interviews from the same trust, produced a total dataset of 29 interviews with 23 participants (see Table 2 for details).

TABLE 2 ABOUT HERE

Among the interviewees at St Tony's there was a substantial degree of 'hybridity', with around half the managers interviewed having either a clinical or research science background. The interviewees had thus progressed through, and been shaped by, different epistemic communities during their careers (cf. Bresnen *et al*., 2019). It was notable that most interviewees had spent time working outside the NHS, and the majority had experience of working in the private sector. This diversity of experience means that the presence of homogenous patterns of orientations regarding PSE should not be assumed. Rather, as examined below, the enrolment of individuals into these values was uneven, partial and conflicted.

Accepted Article

The theme of enterprise and entrepreneurialism had featured prominently in the initial analysis, in marked contrast to a more conventional 'bureaucratic' public management ethos within such settings (du Gay 1993). What made the specialist trust a distinct case was the extent to which organizational strategy and structure were geared towards promoting and taking advantage of an entrepreneurial ethos. This was reflected in the kinds of conduct available to and enacted by middle managers. It is these forms of conduct, and the conflicts it surfaced, that we explore below.

St. Tony's is a single-site, single specialty hospital (serving regional patients but with a quarter of its patients referred from outside the region) with a workforce of over 2,000 and an annual turnover of over £250m. In 2014-15, over 15% of its income came from non-NHS sources (St. Tony's annual report and accounts). Substantial revenue streams were created by research, charity, and joint ventures, which together totalled in excess of £20 million (around half the total non-NHS income). The high public profile of its clinical specialism created prestige for the organization and a strong 'brand' identity, which was recognized and mentioned by clinicians and managers alike, reinforcing their status and power.

The organization was managed through a formal and multi-layered hierarchy, with extra managerial layers providing outward-facing/strategic and inward-facing/operational roles. This underlined the sense that this was a highly strategic and externally networked organization, when compared to most other NHS organizations. This orientation was demonstrated through the creation of a separate division for marketing and communications, substantial clinical outreach activity, and moves towards increased private sector partnerships that were underway before the HSCA was passed in 2012.

Findings

Epistemic boundaries

A pervasive aspect of the commercialization of some of St Tony's services was the impact it had upon the epistemic boundaries of staff and the organization. This could be read in the responses of some interviews who consciously positioned themselves and their organization as different to the 'old' NHS way of doing things:

Accepted Article

There's a lot of hospitals around with [clinical service] centres which have had private centres put up on their doorstep to compete with them. We chose to jump into bed with a private company rather than them open up and compete directly, so we went into partnership. A lot of people don't want to work in partnership with the private sector. That's a very traditional NHS thing. But I think the NHS is changing. There are elements of the old NHS around, and there are inefficiencies. I interact with people from the private sector and I think it's a lot more cut-throat and people lose their jobs more often… But I think we're fairly progressive. (Nicholas, Clinical Director).

This difference could be experienced as a 'shock' for newer organizational members more used to the 'old' ways:

The first thing that shocked me when I came here was how business focused, how performance driven it is … It's about saving money, it's about being efficient, it's about being effective, you know, all the targets and things as well. And I didn't expect that to be honest with you. (Danielle, Associate Director of HR)

These two quotes offer insights into the polarizing effect of what are perceived to be 'new' corporatized ways of doing things, illustrated here with reference to a private sector or business-like mentality. The distinction drawn between these two excerpts is a hard one – public or private, new or old. Some traced this corporatization directly back to the formation of St. Tony's as a foundation trust, presenting opportunities for units which generate revenue (such as research and clinical trials):

Since we've become a foundation trust it's more structured. I think the communication channels are more visible and, you know, the lines of reporting into different people. I think most of the divisions have performance management as their key things, but we are probably the only unit that really brings in income to the Trust and obviously raises the profile of what we do here as well … In terms

Accepted Article

of marketing it's a big shining thing to sell, which I think you might have picked up as well. (Diane, Lead Research Nurse)

Despite this sense of inevitability and the perceived `progressive' positioning of St. Tony's, there was an awareness too that this reconfiguration of the boundary between public and private, and between commercial and publicly funded, was contestable and perhaps contentious. One such boundary was the scope and influence of financial decisions and their effects on clinical staff:

> *I've worked with a private company. I think it's something that a lot of people don't really understand because you're not trained for it, you're very blinkered. When you've worked for the NHS, the private sector is like a separate entity… It is different but you're not trained to do that. That's something that you do learn on the job. So there's nothing that prepares you for that. (Diane, Lead Research Nurse)*

Diane's experience of the private and public sector signifies an awareness of commercial activities but a concern that greater engagement may present a challenge to others without this experience, raising the potential for complexity and conflict in private/public relationships within the trust, a point which Gayle outlined:

> *We have a collaboration with the private sector…there are some clear issues… We're not directly managing the staff but yet they're working from our protocols and treating using our techniques. That has been really challenging you think, 'you've not done this, you've not done that…' and they're supposed to be setting up a new service, and you're thinking, 'well, it's nothing to do with me'. But I think ultimately what we're worried about is the private sector are in St. Tony's so, if something does happen, if an untoward incident, that the mud will… come back here because they're still in St. Tony's and everybody will forget actually, no, it was treated by the private sector, it's nothing to do with us, because they're in the building. (Gayle, Clinical Education Lead)*

Accepted Article

The unease with which Gayle attempts to maintain some distance from what she perceives to be basic problems highlights wider tensions associated with the adoption of entrepreneurial ideas and practices allowing the private sector 'in the building'. This sense of unease speaks to the complex work of 'fitting' between different epistemic stances that PSE implies (McGivern *et al*., 2015). As Gayle's comments make clear, this work of fitting does not always result in resolution. Rather, as discussed below, attempts to fit represent an ongoing internal struggle between compartmentalization and dissonance.

Compartmentalization and dissonance

The excerpts presented above articulate a variety of positions regarding the perceived necessity or legitimacy of becoming more commercially or business minded, as well as individuals' personal proximity to these new arrangements. Within the trust, there was wide awareness of the range of commercial activities undertaken:

> *We've got (...) a quite savvy exec team to say, 'don't just work in isolation, put our hands in a few pies'. I think that's what they've done to make the financial buoyancy. So our private patient venture, a massive income generator for them, for us, reputation, the charity again you know. They're always looking for our links with the university and huge income coming from the university. That's down to the reputation and what we do here. Whereas you wouldn't have that elsewhere. You just wouldn't have that charity, that private sector support coming in, those income streams don't exist. (Becky, Service Manager, Clinical Support)*

The resultant tensions and dissonance this gave rise to were managed to some extent through compartmentalization by organizations and individuals. St. Tony's achieved this compartmentalization organizationally through structures that separated internal and external facing roles. As Matthew explains of the Clinical Trials Unit:

Accepted Article

You could almost say we're almost a private enterprise within an NHS organization in the way in which we're trying to business manage the unit. (Matthew, Operations & Business Manager, Clinical Trials Unit)

Our interviewees communicated this sense of boundedness, which appeared to facilitate compartmentalization by individuals such that the demands of commercial activities might be effectively contained in parts of the trust:

[R&D] is very different. It's an income that we generate… we get money with commercial trials that come to us… We'll cost it out in terms of the time it takes of a nurse, a doctor and an administrator and all the tests we have to do…and we'll work out how much income we've got… Because obviously I have to pay salaries of staff as well so it has to be matched against like a projected income to keep my staff... So I will look at my statements each month and just make sure I've got enough money coming in to pay for my staff... (Diane, Lead Research Nurse)

In Diane's example, the tension of managing a commercially active and strategic organization resided organizationally and individually at the mid- to senior- manager level and was about reconciling the need to generate income and the uncertainties that arose from that, including the need to employ staff and to have an infrastructure ready to undertake the available work. This tension is an entirely different mind-set than one would expect for management elsewhere in the NHS, where the challenge is to work within a fixed or shrinking budget, which might require cost reductions and workforce efficiencies, but within a more transparent and predictable funding regime. This conveys a clear sense of the complex relationship between commercialization and the ethical conduct of management in the enactment of public service values.

The charity and marketing departments within St. Tony's were similarly units where a more commercial and corporate mentality predominated, and where brand identity was emphasized.

I think you absolutely have to understand branding, absolutely have to be able to say to yourself, if I am St. Tony's, how do I behave, what do I do, you know, where

Accepted Article

do I go, how do I talk to people, what do I look like, and I think that in itself is something you have to learn to do (…) I don't think many (NHS trusts) do (this) actually (…) Our brand very much is St. Tony's rather than NHS. (Marie, Head of Marketing & Membership)

Marie was explicit on the degree to which the charity had driven the corporate marketing function and the focus on corporate identity in the trust:

For us I think it's very much come from the charity, and having to be out there in the marketplace with our sort of charity proposition, because the charity raises over £12 million a year and you wouldn't be able to, you know, do that without the marketing function and you need it to be consistent (Marie, Head of Marketing & Membership)

Indeed, even income generation activities, such as outreach clinics, were seen as primarily opportunities to disseminate the 'St. Tony brand' across the region:

we do [clinical service] at outreach clinics, and I think it's badging that a bit more, it's not just that our doctors will go and have the clinics at the [local hospital], it…will be the outpatient clinic and then it will be 'St. Tony's At [hospital] X' (Hayley, Health & Safety Manager).

Despite this compartmentalization of commercial activity, awareness of the importance of the St. Tony's brand was raised by all kinds of staff, from clinical directors to lead nurses;

You know that you have to keep that branding up there. You know you have to be professional and deliver at all times. There are probably other (trusts) that don't have that same drive. (Beryl, Divisional Lead Nurse).

The case of the joint venture at St Tony's with a private company is a clear instance of where such compartmentalization was difficult to maintain, particularly when problems arose:

Accepted Article

(people feel that) the private patient is somebody else's problem when they're not, it's a joint venture. Just because it's got a different name, we're part of that process. (…) I understand that, but it's getting that message out to everybody else… it's not us and them, they're not some random company that's stuck over there and had nothing to do with us, they just happen to see our patients. Actually it's a joint venture… There might be a bit of a problem, you might have a problem about whether you think you should be doing X, Y and Z, but they're still patients there. (Julie, Head of Finance)

The consequence of this failure of compartmentalization was, for some, a matter of ethical concern.

Ethical concerns

Ethical concerns related to St. Tony's at an institutional level around the strategy of commercialization and, at an individual level, with the requirements to engage commercially and entrepreneurially. At the institutional level, respondents were concerned about the ways in which the organization was being represented as a business rather than projecting the public service values which the NHS was seen to embody;

This organization does seem to have a clear vision of where it's going. Not everybody agrees with that, they've done some quite controversial things, there's links with private healthcare and there's a lot of people who don't like that. (Nicholas, Clinical Director)

Others were more equivocal, while still articulating the tension implicit in the strategy, and particularly in the joint venture activity:

I think people are positive about it, it is an interesting engagement in that hopefully it is mutually beneficial (…) and then (there's) this business about should we, are the two opposed to each other? Well here there is this big thing, that any money or proceeds from (the joint venture) are being pumped into the

> *NHS so that concept is a good one. Will it work? Well, we'll wait and see. Early days. (Brenden, Clinical Director)*

Additionally, commercialization and PSE presented an ethical concern for clinical staff since some services required payment for treatment;

> *My colleague set up a private [clinical service] business… And the St. Tony's [centre] have bought his company to provide [clinical] care. So although ethically I don't know whether that's the way we should be going on or not, because I've got all these ethical debates as to whether at end of life should be paying for their treatment. I don't know; it's another decision. (Beryl, Divisional Lead Nurse).*

For Beryl, this ethical concern had another dimension, as refusal to engage might have negative consequences for her career prospects with increasing private sector involvement in healthcare:

> *…but I need to be part of that clinic because I don't know where my future is. And I've got to have an understanding of what's happening in the private sector (Beryl, Divisional Lead Nurse).*

The wider pressure of revenue generation at St. Tony's was experienced acutely by Ellen:

> *I had about 25 projects within that team that I had to fully understand the technical side and the regulatory side and then also – and this is the side I hated to this job – was I had to make money every month. I had to make twelve and a half thousand pounds a month per staff member and if I didn't make it I was called into question by the director. It was really hard. It's really hard when you love the science and you love the development and you wanted to make things better at the end of the day for people to then be told 'well you're not making any money' (Ellen, R&D Manager).*

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While, for Beryl, the ethical tension lay between quality of care and ability to pay, Ellen's preoccupation was the dominance of this financial logic and its influence on decision-making and behaviour.

Discussion

Focusing on a critical case of a hospital in the vanguard of commercialization, this paper has traced the shifting epistemic boundaries generated by moves towards corporatization, commercialization, and PSE in the English NHS. It has explored some of the tensions experienced by staff as they negotiate boundaries between public and private sector and between public service and for-profit orientations as the trust has engaged in a 'progressive' strategy of maximizing revenue generation supported by a more business-like approach within the organization. As described above, these tensions are played out in the interaction between organizational dynamics and individual behaviours; individuals faced with these tensions and dilemmas have recourse to the broader arguments which legitimize and normalize commercialization and public sector entrepreneurship as an inevitable and, indeed, innovative and inspiring solution to structural problems generated by underfunding of public health services. Although (or perhaps because) a significant proportion of staff interviewed had private sector experience, most were very conscious of the shifting boundaries between commercial and public service activities in their organization and consequent impacts upon their identity work. It may be that the resultant blurring of (professional, managerial and market) logics creates a degree of dissonance for some staff (Bresnen *et al*., 2019; Croft *et al*., 2015), especially those working in NHS commercial departments/units (Bresnen *et al*., 2017a) needing to reconcile the tensions implicit in hybrid roles (Martin *et al.*, 2015; Moralee & Bailey, 2020). This dissonance is managed by some by a (tacit or explicit) rationalization that the greater good of the NHS (or at least, significant parts of it) is served by being oriented towards more commercial purposes, practices, and organization. However, this dissonance is also managed through compartmentalization between commercial and core activities through organizational structures. While the commercial activities of the trust were widely recognized, a degree of compartmentalization served to present a buffer between 'traditional' NHS activities and commercial activities, including R&D, charity and marketing and on-site joint ventures

Accepted Article

with private companies. Where compartmentalization failed, this generated ethical dilemmas for some individuals due to perceived challenges to their ethos of public service. Several perceived the potential for ethical dilemmas arising from this, but their comfort or discomfort with these developments could not be neatly predicted from their background, career history or their clinical or managerial professional orientation.

Research in the non-profit sector has shown that commercial revenue generation can compromise the sector's core values and contribution to civil society (Eikenberry & Kluver, 2004). Our data suggests a corresponding trend in the public sector, in which the charitable arm of the organization acts as a 'hinge' through which commercial and financial interests can be situated more palatably within public service delivery (c.f. du Gay *et al.*, 2012). St. Tony's charity seemed to be pivotal as an entry point for their commercial activities, encouraging and legitimizing the need for commercial engagement while arguably softening its otherwise perceived hard entrepreneurial edge. Charitable activities also normalized aspects of commercialization, such as marketing and branding (to maximize income), allowing them to take hold more subtly on people's orientations to their outreach work. For commercial and charitable activities, the enrolment among staff in a commercial logic was further facilitated by the rationale that such entrepreneurialism was necessary to cope with systemic financial constraints of the NHS in a decade of austerity (Lunt *et al*., 2015), and even necessary in order to protect the quality of care for non-private patients.

The paper also sheds light on how specific commercial initiatives in public sector organizations affect the organization as a whole. Wider research suggests that 'commercialization results in mission drift, goal displacement, and the loss of idealism' (Park *et al*., 2021, pp. 14-15) and certainly the experience at St. Tony's points towards an organizational hybridity that blurred the boundaries of public service and private sector. Internally, organizations engaged in commercial activities can partly decouple a commercial logic from a professional one through the formation of quasi-units within the organizations, via commercial departments, private patient units, or subsidiaries (c.f. Meyer & Rowan, 1977). At St. Tony's, this included commercial partnerships with private sector organizations, significant in scale and profile but compartmentalized from the rest of the organization. This more

Accepted Article

explicit confrontation with commercial values and activity was thereby contained to some extent, in terms of its impact on knowledge, identity and ethics. Yet, the pervasiveness of commercialization shapes all departments in balancing income and costs (as an extension of the market logic) and by the organization-wide embrace of the values of marketing and branding, to such an extent that it would encapsulate even charitable and R&D activities. By contrast, individuals are less able to compartmentalize this distinction and tensions and ethical dilemmas become more acute.

The analysis also underlines the degree to which commercialization is becoming embedded in this and other NHS organizations. As a single case, the study in itself is not intended to provide evidence of the spread of commercialization across the sector, only the effects of significant commercialization within one organization and over time. Given its financial health, St. Tony's was not typical of other organizations in the English NHS but, as an organization in the vanguard of commercialization in a corporatized context, it does offer a privileged insight into how staff understand and respond to these developments, and points towards longer-term implications for the mission and focus of healthcare.

Our argument for the wider relevance of this research rests on broader political and social drivers, in particular (a) government policy trajectory toward commercialization and enterprise in the NHS, and (b) fiscal constraints on budgets and increased pressures driving the search for alternative sources of revenue. As COVID-19 impacts on the public finances and imposes direct pressure on health services in multiple ways (Charlesworth, 2021), we might expect to see similar patterns of increased commercialization in other healthcare organizations, albeit with different strains given the type of organization, degree of entrepreneurial leadership, history of previous commercial strategies and so on. Our research therefore points towards a research agenda which attempts to systematically account for such variance between cases. More broadly, however, the influence of a commercial logic across St. Tony's points to reform within the NHS, towards new forms of PSE. This is potentially more significant as its effects are more subtle and pervasive, and possibly less likely to generate resistance and/or foster enrolment among staff, particularly insofar as they can be aligned to a discourse of improved patient care in straitened times and steered away from a discourse of improved efficiency (Bailey *et al.,* 2019). Moreover, the approach is likely to gain more traction given the limited evidence

Accepted Article

so far of the `failure' of the malign effect of this form of commercialization; for example, in terms of financial deficits or job losses arising from 'poor' commercial decisions. The extent to which this commercialization may be driven across other corporatized fields across the public sector in the UK and elsewhere is an open question, although all are subject to the same winds of policy discourse and similar economic/fiscal pressures.

Conclusion

The corporatization of the English NHS, established over recent decades through successive reforms and broadly informed by a NPM agenda, has created the conditions which have precipitated an increasingly commercialized and more intensively entrepreneurial healthcare system in England. While some organizations have been less willing or able to exploit the increased autonomy presented by corporatization and the formation of Foundation Trusts, the financial pressures generated through austerity in the last decade have generated movement towards exploring alternative revenue streams as trusts seek to shore up deficits due to underfunding of core activities. This has led to the gradual normalization of public sector entrepreneurship, accompanied by legislative changes to encourage greater efforts among healthcare organizations to grow revenue from non-core activities. In turn, this has created challenges to traditional understandings of mission and identity for those working within NHS organizations and, in places, ethical dilemmas where commercial and entrepreneurial logics collide with the established public service ethos within the NHS.

The pressures of austerity have also created an apparently self-evident rationale for increasing emphasis on commercial and entrepreneurial behaviour, while at the same time downplaying practical and ethical concerns about such shifts in the logic and focus of NHS trusts. PSE could not exist in its current form were it not for previous formal organizational shifts towards corporatization associated with managerialism and NPM. In this way, we believe that the current experience of PSE might also be reconfiguring boundaries in different ways to previous managerial/neo-liberal reforms in the NHS. Despite the apparent aversion to NHS privatization amongst the public (Timmins, 1995), tenets of PSE are becoming normalized into NHS custom and practice through the Private Finance Initiative (PFI), the development of the bio-life science sector (as a source of revenue for the UK if not

Accepted Article

individual organizations), and the creation of commercial opportunities within organizations (such as selling `spare' real estate or exploiting `under-utilized' assets such as laundry). In spite of its popularity, since its inception the NHS has provoked considerable political contestation regarding its funding (Charlesworth & Bloor, 2018). When corporate and commercial practices are encouraged on the basis of helping to maintain financial stability, then this normalizes and legitimates practices anomalous to the formal organization of publicly funded and accountable care (du Gay *et al*., 2012).

Further research is needed to trace the expansion of PSE across different kinds of NHS trusts and healthcare providers, particularly in organizations with limited commercial or charity activities, in light of ongoing underfunding and political exhortations to explore revenue generation. While the recently published Health and Social Care Bill White Paper (DHSC, 2021) suggests that the future policy direction may be away from the aggressive promotion of competition which marked the 2010s and towards a more centralized and integrative model of commissioning and provision, it is as yet unclear how the balance of competition and collaboration will take form across the heterogeneous systems and partnerships that are currently in nascent form. At the same time there is no sign of funding pressures abating. More broadly, there is a need for greater research into the process by which corporatization enables and encourages commercialism in these and other public sector organizations, and with what effects upon the provision of publicly funded services and upon the staff who provide such services.

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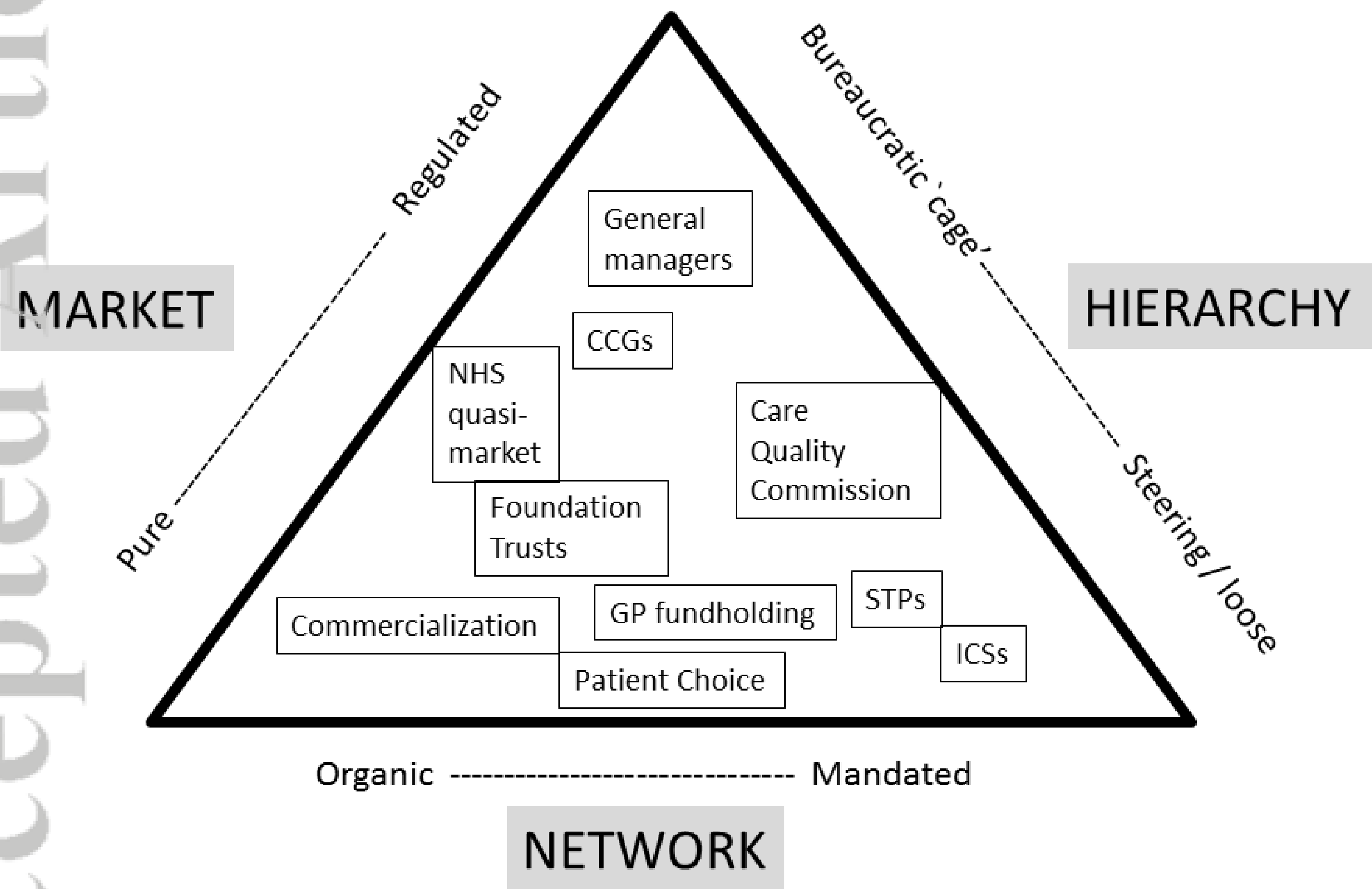

Table 1: Summary of key NHS policy shifts since 1980

Date	Policy/ Reports	Agenda	Key Components of Change
1982	Griffiths report	Efficiency; financial accountability	General management function; separate management budgets; top-down performance reviews
1989	Working for Patients	Efficiency; bureaucracy; market-reform patient choice	Quasi-market splitting purchasers (health authorities) from providers (hospitals).
2000-2004	NHS Plan; Reform and Profs Act; Agenda for Change; Health and Social Care Act 2001;	Quality standards; patient choice; modernisation; market-reform	Reorganisation of commissioning into Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs); Provision moves towards creation of Foundation Trusts (FTs); new GP contracts introduced; Commission for Health Improvement (CHI) and National Institute for Clinical Excellence (NICE) created; CHI then replaced with Health Care Commission (eventually Care Quality Commission).
2010-2012	Liberating the NHS; Health and Social Care Act 2012	Managerial efficiency; bureaucracy; patient choice; market-reform; medical leadership	Replaced SHAs and PCTs with Clinical Commissioning Groups (CCGs). Created a national arms-length commissioning body (NHS England); Changed competition and commercial income laws.
2014-2020	Five Year Forward View 2014; NHS Plan 2019; Health and Care Bill 2021 (draft)	Austerity spending; De-centralisation and devolution; Person-centred care	Local devolution and integration encouraged through variety of provider networks and partnerships; Continued rise in sub-contracting and shared/delegated commissioning arrangements; Ambiguity created in top-down accountability relations and tensions between collaboration and competition; Draft Health and Care Bill attempts to enshrine entrepreneurial government in law through increased powers to arms-length bodies and loose steering of emergent policy change.

Accepted Article

Table 2: Sample characteristics

Name	Age	Sex	Mgt Type	Grade	Job
Adrian	60+	Male	Functional	8c	Head of Facilities
Matthew	50-60	Male	General	8b	Operations & Business Manager Clinical Trials Unit
Gavin	30-40	Male	General	8d	Network Services General Manager
Marie*	40-50	Female	Functional	8b	Head of Marketing & Membership
Annette	40-50	Female	General	8d	Acting General Manager / Joint Venture
Danielle*	30-40	Female	Functional	8d	Associate Director of HR
Ellen	40-50	Female	Functional	8b	R&D Manager
Julie	30-40	Female	Functional	8c	Head of Finance
Simon	30-40	Male	General	8c	Divisional Operations Manager
Thomas	18-30	Male	Functional	8a	Divisional Finance Manager
Becky	30-40	Female	General	8a	Service Manager Clinical Support
Gayle*	30-40	Female	Clinical	8a	Clinical Education Lead
Diane*	40-50	Female	Clinical	8a	Lead Research Nurse
Olivia	18-30	Female	General	8a	Clinical Services Manager/Joint Venture
Pavak	30-40	Male	General	8b	Network Services Manager
Hannah	40-50	Female	General	8b	Clinical Service Manager
Nicholas	40-50	Male	Clinical	9	Divisional Director
Nina	40-50	Female	Clinical	8b	Divisional Lead Nurse
Brenden	50-60	Male	Clinical	Cons.	Divisional Director
Joanna	30-40	Female	General	8c	Network Services Deputy General Manager
Hayley*	40-50	Female	Functional	8a	Health & Safety Manager
Ian	30-40	Male	Functional	8c	Deputy Chief Information Officer
Beryl*	40-50	Female	Clinical	8c	Divisional Lead Nurse

**** Participant also completed a follow up interview***

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