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A Comparison of the Equity-supportiveness of Organizational Cultures of (Public) NHS

Organizations and (Private) Social Enterprise (SE) Providers

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<u>Abstract</u>

<u>Title:</u> A Comparison of the Equity-supportiveness of Organizational Cultures of (Public) NHS Organizations and (Private) Social Enterprise (SE) Providers

<u>Theory:</u> New Public Management (NPM) has been the most influential paradigm in public administration in the last three decades. NPM-driven ideas such as provider competition, privatisation and patient choice have resulted in increased interest from recent UK governments in Social Enterprises (SEs) for delivering public health services. NPM-based changes have been criticized for creating inequitable provision of healthcare and increasing unjust health inequalities. It is worth asking whether equity for patients is promoted equally effectively by public (NHS) organizations and SE providers.

<u>Research Aims and Methodology:</u> A mixed methods approach was employed. The quantitative strand used a survey to compare the equity-supportiveness of NHS and SE organizational cultures [124 respondents (68 NHS and 56 SE staff) from 21 organizations (12 NHS and 9 SEs)]. The qualitative strand used semi-structured interviews with 27 SE staff members to examine organizational changes in SEs and the impact of these changes on equity in service provision.

<u>Findings:</u> By achieving better alignment with organizational values, reducing bureaucracy, speeding up decision-making, giving staff more autonomy and responsibility, encouraging initiative, risk-taking and innovation, involving staff more actively in strategic decision-making, and making better use of technology, Social Enterprises are promoting equity to an equal or greater degree than public (NHS) organizations.

<u>Implications:</u> However, the SE model (currently limited to community healthcare services) remains unclear and problematic, suggesting caution in its use by larger NHS acute Trusts. More research is needed before a policy to support the adoption of the SE model in public service delivery is mainstreamed.

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Chapter 1: Introduction

In this chapter the organizational form of hybridity is introduced. Hybrid organizations are contrasted with public organizations. The concept of equity is then introduced and its relevance to a study of organizational form, in particular, to the organizational form of hybridity is explained. By highlighting the paucity of evidence on the relationship between hybridity and equity, a case is prepared for analysing hybridity through the lens of equity. To clarify this relationship, the use of organizational culture as a potential mediating variable between hybrid organizational form and equity performance is proposed. The purpose of the research is then concretised through a statement of the aims of the research, the research questions and the hypotheses. The chapter ends with an outline of the structure of this thesis.

1.1. Hybridity

Recent years have seen UK governments actively encourage hybrid organizations such as social enterprises in playing a greater role in the provision of public health services. The growth of hybrids in the public health sector has been supported through various initiatives such as the 'Right to Request' which facilitated spin-offs from the public sector (Department of Health, 2011). The emphasis of recent UK governments on the delivery of public health services through private and voluntary sector organizations and, in particular, through hybrid organizations such as social enterprises raises important questions about the relationship between the nature of the organization delivering a public service and equity in service provision. This relationship is explored in this research project.

Most definitions of hybrid organizations stress that they are a new organizational form and that they combine elements that have traditionally been seen as belonging to mutually exclusive spheres. Thus, Low (2011) defines hybrid organizations as those that 'combine two elements previously thought of as discrete and unlikely to be present in a single organization: social purpose alongside a profit-driven culture' (p. 1). In the view of Anheier (2011; p. 1), a hybrid

organization is one that 'contains diverse elements and corresponding logics drawn from nonprofits, public agencies, and business firms'. Hybrid organizations may be contrasted with purely (or predominantly) public organizations (such as the NHS) and private organizations such as private hospitals.

These hybrid organizations come in a variety of forms – cooperatives, charities, mutuals, social enterprises, etc. For the purposes of this research project, hybridity will mean social enterprises providing publicly financed health care services, in particular, those social enterprises that have spun out of the NHS under the Right to Request programme (the rationale for this choice is presented later in the methodology section). Social enterprises are defined as 'businesses with primarily social objectives, the surpluses from which are principally reinvested for that purpose in the business or community rather than driven by the need to maximise profits for shareholders and owners....[Social enterprises are] independent bodies delivering services, previously delivered in-house, under contract' to the commissioning body (National Audit Office, 2011; p. 4).

Academic studies of hybridity may be divided into two categories: studies that use hybridity as the dependent variable or the phenomenon to be explained (i.e., studies which answer the question 'why do hybrid organisations emerge') and studies that use hybridity as the independent variable to explain other related phenomena (i.e., studies which analyse the effects of hybridity on hybrid organisations and their political environment) (Anheier, 2011; p. 4-5). This research project proposes to use the hybrid organizational form as an independent variable; it aims to examine the effects of organizational form (public, hybrid) on organizational culture around promoting equity in public and hybrid organizations providing publicly financed cardiac and related health services.

In this section, the concept of hybridity was introduced. The next section introduces another concept that is central to this research project - equity.

1.2. Equity

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In this section, the concept of equity is defined and a case is made for examining the effects of hybridity on equity as a way of contributing to the academic debate on hybridity and equity.

Equity is concerned with how *fairly* health resources are distributed throughout a group of people. Equity is about distributing resources, opportunities, access, etc. *fairly*, i.e., according to need, not *equally*. Equity can be analysed in terms of: a) equal access to care, or equal use, for equal need, b) equal quality of care for equal need, and c) equal health outcomes for equal need. Flowers and Pencheon (2002) define equity as 'equal resource (access, use or quality) for equal need' (p. 1). Equity means ensuring that health care services serving disadvantaged populations are not of poorer quality or less accessible and that extra efforts are made to reach those whose health is worse (Acheson, 1998). An equitable situation is one where provision matches need (EMPHO, 2005; Flowers and Pencheon, 2002). An equitable situation may be depicted visually as
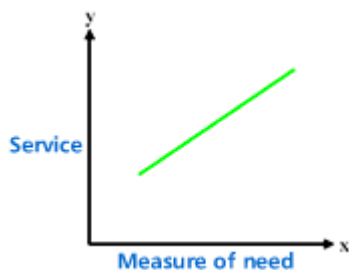
Fig. 1.1 East Midlands Public Health Observatory (EMPHO), 2005.

Conversely, an inequitable situation is one where there is a lack of relationship between provision and need. An inequitable situation may be represented diagrammatically as

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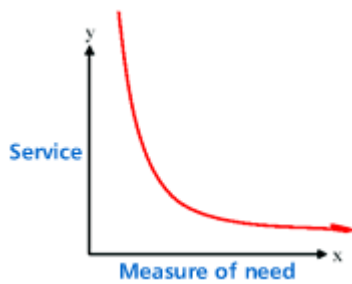
Fig. 1.2. East Midlands Public Health Observatory (EMPHO), 2005.

This section defined the concept of health equity. The next section provides a brief overview of some of the major philosophical perspectives on health equity.

1.2.1. Theories of Health Equity: A Brief Overview

Health inequalities which stem from inequitable social and economic policies and unequal access to health or its determinants are seen by many philosophers, economists, and health policy analysts as unjust. Norman Daniels (Daniels et al., 2004) applies John Rawls's (1999) theory of justice to health to argue that protection of the principle of fair equality of opportunity for everyone implies protection of health and the social determinants of health. Health is seen as a subset of opportunity and, therefore, considered one of the primary social goods to which all should have equal access in a just society. Amartya Sen (Sen et al., 2004) argues that equality should be sought not only in actual health achievements, but also in the capabilities to achieve good health (Sen et al., 2004). As social justice would require a fair distribution of capabilities, and health is 'a critically significant constituent of human capabilities which we have reason to value', justice would mean an equitable distribution of the opportunities to achieve good health (Sen et al., 2004). In Sen's view, therefore, inequalities in opportunities to be healthy are unjust.

Sudhir Anand builds upon Sen's theory to argue that there is an injustice in permitting health inequalities emanating from socio-economic disparities (Anand, 2004). As ill-health reduces the scope of human agency, inequalities in health deprive people of the most fundamental

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human freedoms and opportunities. Moreover, as health inequities often compound the disadvantages suffered by already vulnerable and marginalized groups, they are doubly unfair (Anand, 2004). Sir Michael Marmot, chair of the World Health Organization (W.H.O.) Committee on Social Determinants of Health, argues that equity in health is desirable not merely because it enhances opportunity and, thereby, contributes to Rawlsian justice, but because health is valued by people for its own sake (Marmot, 2008). The World Health Organization's report on the social determinants of health, *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health* (WHO CSDH, 2008), concludes that many of the health inequalities found around the world today are unjust because they are rooted in unfair social structures and inequitable political and economic institutions.

This section presented a brief overview of some of the major philosophical perspectives on health equity. The next section explains why hybridity is relevant to considerations of equity and argues the case for the choice of hybridity as an analytical perspective in this research project.

1.2.2 Why Health Equity as a Way of Analysing Hybridity

The World Health Organization's report, *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health* (WHO CSDH, 2008), explains that the primary motivations for emphasizing health equity as a key aim of any health system are social justice and 'the ethical imperative to alleviate avoidable suffering' (WHO CSDH, 2008; p. 121). 'Social injustice,' states the report, 'is killing people on a grand scale' (p. 26). Equity is one of the bedrock principles of the UK's National Health Service (henceforth, the NHS). According to Pollock and Price (2011), the NHS was created in 1948 out of a highly inequitable patchwork of healthcare provision made up of charities, municipalities and private providers. The NHS was conceived, Pollock states, as a universal, comprehensive health service that was free at the point of delivery and available to all on the basis of clinical need, not the ability to pay. Ensuring equal care for equal need was a central goal of the NHS. Sir Michael Marmot's recent report, *Fair Society, Healthy Lives (The Marmot Review)* (Marmot, 2010), further underscores the centrality of health equity. Wilkinson and Pickett (2009) also argue in *The*

Spirit Level: Why More Equal Societies Almost Always Do Better that inequality is linked with many social and health-related problems.

Equity continues to remain one of the fundamental principles of the NHS. *Equity and Excellence: Liberating the NHS* (Department of Health, 2010), the white paper by the Department of Health which sets out the role of Social Enterprises in the provision of public healthcare, rightly begins with the word *Equity*. In placing equity at the head of the title, the report underscores equity as a core value of the English National Health Service and also sets outs the expectations for the role that Social Enterprises are expected to play in providing public services. Equity is, thus, highlighted as a primary reason in advocating a stronger role for Social Enterprises in the delivery of public services.

Hybrid organizations such as Social Enterprises are thought to promote equity as they are better able to serve marginalized and under-served populations who fall through the cracks of established public services. According to the NHS Alliance, 'Social enterprises, and the third sector in general, meet the needs of people for whom statutory provision is poor – the so-called 'service deserts' which often arise either because of high costs or the failure of public services to ensure equity' (NHS Alliance, 2008; p. 2). A report by the National Audit Office (2011) listed some of the strengths of social enterprises; among them were 'boosting social inclusion', 'tackling unmet need', and 'delivering services to communities that often receive little or no support' (p. 11).

At the same time, the encouragement of hybridity in the provision of public services also has the potential to weaken equity (Karre and Brandsen, 2011). The problem of *Mission Drift* is often mentioned in the literature on hybridity (Pestoff, 2011; Hasenfeld and Garrow, 2011; Low, 2011). *Mission Drift* refers to an overemphasis on economic goals at the expense of the social purpose of an enterprise (Pestoff, 2011). As Pestoff explains, 'For social firms operating in the mainstream economy, there are serious risks of isomorphic forces gradually diverting them from their social goals' (Pestoff, 2011; p. 23). Pestoff (2011) found that, over time, Swedish consumer cooperatives gradually metamorphosed into entities very similar to ordinary private firms. Hasenfeld and Garrow (2011) cite a study by Jurik (2006) of social enterprises

that were attempting to assist welfare-dependent people in becoming self-employed. The study found a gradual shift in the dominant orientation of the social enterprises from 'social welfare logic to business logic' (Hasenfeld and Garrow, 2011; p.12). Yunus (2007) asserts that 'in the real world, it will be very difficult to operate a business with the two conflicting goals of profit maximizing and social benefits. The executives of these hybrid businesses will gradually inch toward the profit-maximization goal, no matter how the company's mission is designed (Yunus (2007), cited in Pestoff, 2011; p. 24)'.

Hasenfeld and Garrow call the business enterprise motive 'the Trojan horse that invades the social service mission of the organization' (2011; p. 11).). In a study of a not-for-profit Social Enterprise, Low (2011) found that the directors' personal interest in using their organisation's talent pool to achieve commercial success in the music industry 'demoted the social objectives of the company into second place' (p. 302). In his summary, Low says that 'an organisation that is founded on a social principle may still display behaviour that is more usually associated with the for-profit sector. The organisation may still trumpet its values throughout its communications while acting in a way that undermines its claims' (Low, 2011; p. 304). Pollock et al. (2007) assert that 'the evidence suggests that in a competitive environment nonprofit providers behave much like for-profit providers and this has a negative impact on quality of care and staffing levels' (p. 7).

The currently available evidence on the relationship between hybridity in organizational form and equity in public healthcare provision is ambivalent, and there is a clear need for further research into the subject. Miller and Millar (2011) state that 'the research evidence available regarding the performance and outcomes of health services delivered by social enterprises is limited (p. 11). They conclude that there is 'a strong case for further research both into the performance of social enterprises delivering health care and also the impact of social entrepreneurship in meeting health care needs and inequalities' (p. 12). The Public Administration Select Committee (2008) which examined the question of whether the third sector should deliver public services found that the 'evidence base does not yet exist' (p. 83). The Committee's report stated that

'the central claim made by the Government, and by advocates of a greater role for the sector in service delivery, is that third sector organisations can deliver services in distinctive ways which will improve outcomes for service users. We were unable to corroborate that claim. Too much of the discussion is still hypothetical or anecdotal. Although we received a great volume of response to our call for evidence, much of it admitted that the evidence was simply not available by which to judge the merits of government policy' (Public Administration Select Committee, 2008; p. 3).

The National Audit Office (2011) found that 'there is currently very little hard evidence of the benefits social enterprises are delivering because they have not had time to demonstrate a track record' (p. 6). In their systematic literature review on the structure and performance of not-for-profit health care organisations (which included Social Enterprises), Pollock et al. (2007) concluded that 'There is no consistent evidence that nonprofits perform better than other ownership forms and there is little research of their impact on access to services... There is no evidence to support the government policy in England of using nonprofits to switch from an integrated, publicly-owned and provided system to a provider- or firm-based system where market incentives and principles apply.' (p. 7).

This research project intends to contribute to the evidence base on the relationship between hybridization of service providers and equity in health care provision. It aims to add to the evidence base to inform policy on the involvement of hybrid organisations in the provision of public health services. It may also contribute to theories of marketisation of public health services. This research acquires added relevance in view of the Health and Social Care Act 2012 encouraging the contracting out of statutory health care services to hybrid social enterprises.

In this section, the concept of equity was introduced and a rationale was presented for examining the relationship between hybridity and equity. The next section introduces another important concept, that of organizational culture, and explains its role in this research project.

1.3. Organizational Culture

1.3.1. What is Organizational Culture?

In this section, the concept of organizational culture is introduced, and its relationship with hybridity and equity is made clear. The complexity of the *organizational culture* construct is investigated in some detail. The difficulty in defining this term precisely is brought out through a discussion of the plurality of formulations and the commonalities shared by these diverse formulations. Of the many definitions available, the definition that was used in this study is introduced. Some criticisms that are made of organizational culture studies are discussed as a preliminary to justifying the approach to the study of organizational culture taken in this project.

Organizational culture is one of the most widely researched, and disputed, phenomena in organizational scholarship (Janicijevic, 2011). Described variously as an intangible atmosphere pervading an organization, as 'a certain "feel" about...[a] school, university, or large corporation' (Meek, 1988; p. 461), and as an expression of the unique personality and individuality of an organization (Eldridge and Crombie, 1974; p. 88), the term has remained slippery and extremely difficult to pin down. Despite its amorphous and elusive quality, the importance of the term has grown over the years, and it has now become a staple of policy discourse. Considered by many as an important determinant of, or influence on, organizational performance, studies investigating the relationship between organizational culture and the functioning and performance of all kinds of organizations are on the increase (Janicijevic, 2011).

The concept of organizational culture has acquired particular salience for public service providers. Jung et al. (2009) state that 'organizational culture is widely considered to be one of the most significant factors in reforming and modernizing public administration and service delivery' (p. 1087). In the context of public healthcare in the UK, organizational culture came to the forefront of debates about the organization of healthcare after the appointment of Sir

Liam Donaldson as the Chief Medical Officer in 1998 (Scally and Donaldson, 1998; Donaldson, 1999; Donaldson, 2000). Donaldson (2000) argued that the NHS needed, above all, a culture change. His vision of clinical governance catapulted organisational culture 'to the top of the healthcare agenda' (Stevenson and Baker, 2005; p. 192). Since then the importance of organisational culture has not diminished and the concept continues to exercise a strong hold on the imaginations of politicians and policy-makers. Having indicated the contemporary relevance of the concept of organizational culture to healthcare policy, it is now worth asking what organizational culture is, and how the concept has developed over the years.

The concept of *organizational culture* traces its origins to the concept of *culture.* The history of the concept of *culture* is characterised by complexity, disagreement and contestation. Williams (1976) called *culture* one of the two or three most complicated words in the English language (p. 87). As a testimony to the rich diversity (and accompanying confusion) in the conceptualization of the term, Kroeber and Kluckhohn (1952) were able to find 164 definitions of culture in the literature as early as 1952. Since then the number of definitions of culture has, if anything, increased.

The unresolved differences of opinion about conceptualizations of the parent term *culture* have flowed into conceptualizations of the derived term *organizational culture*. Despite the existence of a long history of research, agreement on the definition of the concept remains elusive. According to Skerlavaj et al. (2007), the concept of organizational culture has been deployed in a number of ways in varying contexts to explain a wide range of phenomena. As each usage differs slightly and adopts a slightly different slant, there is no definition that is universally agreed upon. Pettigrew (1990) described organizational culture as 'a riddle wrapped in a mystery wrapped in an enigma' (Pettigrew, cited in Jung et al., 2009; p. 1087). Allaire and Firsirotu (1984) characterised it as a 'motley, Protean notion' that 'appears under various guises and pseudonyms' in different situations (p. 194). Jung et al. (2009) summed up the generally agreed view that 'organizational culture is and is likely to remain a complex and contested concept' (p. 1092).

The proliferation of definitions of organizational culture has led to a, not surprising, mushrooming of the components of which organizational culture is supposed to consist (Jung et al., 2009; Kralewski et al., 1996; Lurie and Riccucci, 2003). Jung et al. (2009) found that more than 100 dimensions of organizational culture had been proposed. These dimensions span a wide range of organizational phenomena, from 'rituals' and 'structures' to 'warmth', 'satisfaction' and 'esprit de corps' (Jung et al., 2009; p. 1087; Ott 1989; Van der Post et al., 1997). Typologies of organizational culture that attempted to aggregate these dimensions into cohesive clusters corresponding to different cultural types or orientations also varied in terms of number of items, scope and defining characteristics (Jung et al., 2009; Hawkins, 1997; Ott, 1989). Although there is a lack of unanimity on the best or most accurate definition of organizational culture, many of these definitions share common elements. Some of these commonalities are described in the following paragraphs.

Jacques (1952) was one of the earliest to attempt to define the term *organizational culture*. He conceptualised organizational culture as 'the customary and traditional way of doing things, which is shared to a greater or lesser degree by all members, and which the new members must learn and at least partially accept in order to be accepted for the firm's services' (Skerlavaj, 2007; p. 347). Harrison's (1972) definition emphasized 'the ideologies, beliefs, and deep-set values that occur in all firms and are prescriptions for the ways in which people should work in these organizations' (Skerlavaj, 20007; p. 347). Peters and Waterman (1982) understood organizational culture as 'a dominant and coherent set of shared values conveyed by symbolic means such as stories, myths, legends, slogans, anecdotes and fairy tales' (Skerlavaj, 2007; p. 347). Deal and Kennedy defined organizational culture as 'the way things get done around here' (Deal and Kennedy, 1982; p. 90, cited in Skerlavaj, 2007; p. 347). Gregory (1983) defined organizational culture as 'a system of meanings that accompany the myriad of behaviors and practices recognized as a distinct way of life' (Gregory, 1983; p. 364).

Siehl and Martin (1981) and Tichy (1982) conceived of organizational culture as a kind of social glue that bonded the members of an organization together. Drawing on Pettigrew (1979), Wallace et al. (1999) claimed that organizational culture consisted of 'cognitive systems explaining how people think, reason, and make decisions' (Wallace et al., 1999; p. 548 - 549). Pettigrew (1979) contrasted organizational culture with the rational, instrumental aspects of

organizational life that involved the accomplishment of tasks and the pursuit of goals; culture, he said poetically, is the 'more expressive social tissue around us that gives those tasks meaning' (Pettigrew, 1979; p. 574). Sathe (1983) clarified that two elements were important in all these definitions: that organizational culture referred to values, beliefs, etc. that were *shared* between the members of an organizational community, and that organizational culture alluded not only to the visible reality of organizational life but also to the invisible: members of an organization often took cultural beliefs for granted and were frequently unaware of them. Schein (1983) also asserted that cultural understanding is often tacit and has dropped out of the awareness of people who possess it and has become unconscious.

The definition of organizational culture that was used in this research project was the one proposed by Schein (1983). This definition has been used in many recent empirical studies of the organizational culture-performance link (Stock et al., 2007; Scott et al., 2003; Prajogo and McDermott, 2011; Naor et al., 2008; Gregory at al., 2009). Schein's conceptualization of organizational culture has strongly influenced, and is frequently cited in, studies of organizational culture in healthcare settings (Bellot, 2011). Schein (1983) defined organizational culture as 'the pattern of shared basic assumptions – invented, discovered or developed by a given group as it learns to cope with its problems of external adaptation and internal integration – that has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to those problems' (p. 14). Schein conceptualised culture as a layered phenomenon and argued that there were three main levels at which culture could be understood. These layers went from the visible and least important (artefacts) to the invisible and the most important (assumptions):

'Level 1: *artefacts*: the most visible manifestations of culture, including dress codes, rituals, rewards and ceremonies; especially concerned with the observable patterns of behaviour within organisations,

Level 2: *beliefs and values*: espoused beliefs and values; may be used to justify particular behaviour patterns, and for choosing between alternative courses of action (e.g. a belief in evidence; assertions about patient autonomy)

Level 3: *assumptions*: the unspoken, largely unconscious beliefs, values and expectations (e.g. biomedical versus biopsychosocial understanding of health and illness); these may be signalled by artefacts that belie espoused beliefs and values' (Scott et al., 2003; p. 106).

Christensen and Shu (2006) clarified Schein's model of organizational culture. They explained that organizational culture emerges when members of an organizational unit have faced a significant number of problems together and solved them successfully. These problems include adapting to the changing demands of the external environment as well as ensuring internal integration and harmonious functioning. Culture comes into being in a group through a history of successfully facing common problems and solving them together. As a result of these shared experiences, a consensus emerges in the group about the nature of the world around them and about problem-solving strategies that are effective in that world. These, in turn, are based on shared assumptions and beliefs that, because they have worked so well for so long a time, are now taken for granted. These assumptions and beliefs are learned responses to the problems faced by the group. These beliefs have now been internalized and become unconscious or second nature because they have worked reliably over and over again. It is this learned group understanding of ways to solve problems that Schein referred to as organizational culture.

Louis (1983) charted the historical development of the organizational culture concept. She argued that interest in the concept of culture emerged in the 1970s as a result of dissatisfaction with some important limitations of previous organizational research. Most organizational studies till then had been characterized by a reductionist approach. Researchers had divided organizations conceptually into ever smaller components (leadership, strategy, structure, technology, etc.) and looked at each element in isolation. She argued that there was a growing recognition among organizational researchers that this reductionist approach was leaving out something important. It became more and more clear to them that in order to understand an organization's social system, the various elements of an organization had to be considered together as part of a wider whole. Organizational culture, thus, came into being with the promise of a more holistic approach to the study of organisations.

In this section, the organizational culture concept was explored. The complexity of the concept was illustrated and some of the more influential definitions were stated. The historical development of the concept was also traced. In the next section, criticisms of some of the common approaches to the study of organizational culture are discussed.

1.3.2. Criticisms of Organizational Culture Studies

This section discusses some of the criticisms that have been made of previous approaches to the study of organizational culture. A brief overview of these criticisms is provided in this paragraph. The criticisms are discussed in detail in the following paragraphs. A commonly cited criticism of organizational culture studies is that there tends to be a bias towards the views of top management. Secondly, organizational culture studies have been criticised for being solutions-driven rather than understanding-driven. In these studies, culture has been treated like a quick fix. Another limitation of some studies is that they are atheoretical or weakly grounded in any kind of theory. Lastly, while organizational culture researchers have drawn liberally from cultural anthropology in their analyses of organizational culture, they have not adopted the sceptical and critical attitude that characterised cultural anthropology. As a result, there has been much less discussion in organizational culture research of issues of morality, contestation and power than there is in cultural anthropology.

The pro-management bias of many organizational culture studies has come in for heavy criticism. Several studies of organizational culture rely upon the views of top management in assessing an organization's culture (Gordon, 1985; Martin, 1985; Gregory et al., 2009; Skerlavaj et al., 2007; Lee and Yu, 2004). Gordon (1985) examined culture from the perspective of top management because he believed that 'the corporate values held by management are reflected in behaviour throughout an organization' (p. 104). This view of the centrality of management in shaping organizational culture was supported by Martin (1985) who stated that 'in many organizations, corporate cultures are developed from the philosophies of top management and maintained through the acceptance of these philosophies by the organization's members' (p. 148).

This tradition of looking at organizational culture through the eyes of top management has been continued in more recent studies (Gregory et al., 2009; Skerlavaj et al., 2007; Lee and Yu, 2004). In Gregory et al.'s (2009) study, the top management group that was surveyed included the Chief Executive Officer, the Chief Operating Officer, the Chief Financial Officer, the Chief Nursing Officer, the Director of Business Development, the Human Resources Director, the Director of Marketing and the Business Office Manager. The authors of the study argued that top management were the most appropriate informants for learning about the organization's culture because of their macro-level perspective. Skerlavaj et al. (2007) also chose to rely on top management's views because of the latter's strategic and deep knowledge of the company as a whole.

Meek (1988) was highly critical of this pro-management bias in assessments of organizational culture. She argued that behind the over-emphasis on the perspective of top management lay the assumption that culture was owned by management and available for manipulation by them. Ouchi and Wilkins (1985) found in their research a perception that 'it is through culture, rather than formal structure, that large firms can be bent to the will of their masters' (p. 469). Referring back to the cultural anthropology research that was foundational to many analyses of organizational culture, Meek (1988) argued that 'most anthropologists would find the idea that leaders create culture preposterous: leaders do not create culture, it emerges from the collective social interaction of groups and communities. It is unlikely that social anthropologists would postulate that tribal leaders create culture; the chief is as much a part of a local culture as are his tribal or clan compatriots' (p. 459). Ouchi and Wilkins (1985) supported Meek, stating that 'Malinowski and Radcliffe-Brown [eminent cultural anthropologists whose ideas are frequently borrowed by organizational culture researchers] might be appalled by the explicitly pro management and change-oriented bias of many contemporary scholars' (p. 460). Saffold (1988), too, lent support to Meek's argument. He argued that relying exclusively or predominantly on the perceptions of top management assumes that the views of the top management are the ones that count the most. This approach suffers from an ethnocentric bias that privileges the views and values of one group over another (Saffold, 1988).

In opposition to this management-centric bias, Meek (1988) contends that culture needs to be viewed in relation to the entire organization and not as a whip or a sceptre resting solely in the hands of the top management. Views of culture, she asserts, need to take into account the interests of the entire organizational community instead of concentrating exclusively or primarily on those of top management. Culture should be seen, not as a creation of management, but as the collective product of social interaction across all levels of the organization and as a result of the sharing of and negotiations over meanings throughout the organization. People are not passive receptacles, she argues, into which culture can be poured. They are active creators of culture. People throughout an organization constantly produce and reproduce culture in their social interactions and in doing so they also transform culture.

Meek (1988) disputes the absolute power of management or any other group to consciously manipulate culture, taken as a whole. While she recognises the asymmetry of power between management and the rest of the organization and the greater ability of management to influence and change organizational culture, she also asserts that the process is less one-sided and unidirectional than how it is usually portrayed. She objects to the widespread assumption in organizational culture research that 'management creates, changes and imposes "culture" on a passive and uncritical membership - that management creates a cultural milieu in which rank-and-file staff are immersed and have no choice but to internalize its embedded norms and values' (Meek, 1988; p. 462).

Wright (1998) supported Meek's view and opposed the deployment of culture as a tool in the hands of management for top-down control. The view of culture as 'an entity to be acted on from above', she argued, 'tries to mask or erase the politicization of culture' (Wright, 1998; p. 12, 15). The power to define and make meaning, she explained, had political dimensions. Culture can mean very different things, she suggested, depending upon who is doing the defining. She urged a greater emphasis on the politics of the construction of the organizational culture concept. In her view, culture should be viewed as 'not a "thing" but a political process of contestation over the power to define key concepts, including that of culture itself' (Wright, 1998; p. 14).

In support of Wright's thesis, Ouchi and Wilkins (1985) argued that while organizational culture studies had borrowed heavily from sociology, the critical tone that had characterized the sociological literature (Goffman, 1959; Garfinkel, 1967; Berger & Luckman, 1966) was noticeably absent from organizational culture research. As an instance of the sceptical outlook in the sociological literature on organizations, Garfinkel (1967) showed that juries try to make sense of their decisions after having made them. Garfinkel argued that this amounted to a form of social deception. Ouchi and Wilkins (1985) asserted that this 'critical strain…has found an inhospitable environment in schools of management' (p. 463). Wright (1998) supported this interpretation. She found that organizational culture researchers drawing from cultural anthropology often tended to overlook the contestation and struggle for power that characterized the anthropological literature. She considered the absence of an explicit focus on the politics of culture in the organizational culture literature a significant distortion of the anthropological scholarship from which some of the foundational ideas had been borrowed.

It was further argued by Bellot (2011) that the conceptualisations of organizational culture in several popular business management texts, for example, Deal and Kennedy (1982), Ouchi (1981), and Peters and Waterman (1982), were prescriptive and pragmatic (in the sense of emphasizing culture as a solution to practical business problems). Organizational culture, Bellot (2011) claimed, had been slickly packaged and marketed by business academics and management consultants as a quick fix to business problems and as a ready source of competitive advantage. These conceptualisations organizational culture, she suggested, suffered from significant limitations. They tended to be atheoretical (or weakly and unsystematically grounded in theory), tended to be based on the authors' subjective and anecdotal accounts, had usually not been subjected to rigorous scientific testing and verification by independent researchers, were usually not supported by any significant body of empirical evidence and were, therefore, questionable in terms of rigour, robustness and reliability (Collins and Porras (1994) and Collins (2001) being notable exceptions to this trend).

A criticism directed at some organizational culture studies that explore the relationship between culture and other organizational variables such as performance, productivity, innovation, change, etc. is that they, wittingly or unwittingly, endow culture with agency (Prajogo and McDermott, 2011; Valencia et al., 2010, Naor et al., 2008). Studies in which culture is

portrayed as a determinant of organizational outcomes give the impression that culture is an active agent and is capable of doing things. Keesing (1990) criticized these instrumental views of culture: 'How often, still, do I hear my colleagues and students talk as if "a culture" was an agent that could do things...Of course, we profess that we don't really mean that "Balinese culture" does or believes anything, or that it lives on the island of Bali (it is all a kind of "shorthand"); but I fear that our common ways of talk channel our thought in these directions' (p. 48).

In the preceding paragraphs, some of the main criticisms of organizational culture studies - from the pro-management and change-oriented bias to the lack of a critical edge, from an instrumentalist view of culture to the lack of theoretical and empirical support - were outlined.

1.3.3 Operationalization of the Organizational Culture Concept in this Research Project

As stated earlier, Schein's (1985) influential and widely used definition of organizational culture was used in this research project. Based on Schein's framework and the literature on hybridity and equity, some key aspects of organizational culture that were considered to be useful for an understanding of an organization's equity performance were identified. They were:

a) The organization's mission: An organization's mission is its core purpose or ultimate function in society, the most important reason for its existence (Forehand, 2000; Byars and Neil, 1987; David, 1989). For example, the mission of one health care organization is to provide safe, patient-focused and sustainable health services.

b) Organizational goals: An organization's goals are the specific, concrete aims that the organization is trying to achieve. Organizational goals make an organization's (often abstract and general) mission concrete and specific. For example, one healthcare organization has three

main goals: reducing health inequalities, improving quality of services and increasing productivity of staff.

c) Organizational values: Organizational values are about the kinds of behaviour that an organization values in its employees (Somers, 2001; Meglino and Ravlin, 1998). For example, acting with compassion and behaving ethically are common values for many healthcare organizations. Values are the kinds of behaviour that are *actually* valued and practiced. In an organization that truly values honesty and openness, admission of mistakes or below-standard care is encouraged; if admission of mistakes and concerns about quality of care is discouraged, then, honesty and openness are not the organization's true values.

d) The targets that are used to assess individual performance.

e) The role of leadership, both the immediate leadership in the team, service or department, and leadership by the organization's top management, in creating an environment within the organization which is supportive of, and promotes, equity. For example, the role of the immediate leadership may involve setting out clear expectations of standards, communicating values, monitoring performance, coaching and supporting, etc. The role of leadership by the organization's top management may involve showing a commitment to equity, giving priority to equity, articulating and mobilising a clear philosophy of equity, providing resources and training, listening and responding to staff concerns and opinions about equity, etc.

f) The extent of involvement of staff at all levels, but especially frontline staff in making important or strategic organizational decisions. An important or strategic decision is one about the long-term direction, goals, or values of the organization, or about appropriate ways to invest significant financial and human resources. For example, to encourage the involvement of frontline staff in strategic decision- making, one health care organization has members of staff, service users and carers on its board and they have equal voting rights.

g) The ease or difficulty of making important decisions in the organization (i.e., whether a decision requires approval from a number of people; whether it requires a lot of paperwork; whether it takes a long time, etc.). An important decision is one that affects the organization and the way health services are delivered (it is not merely a personal decision), involves some kind of change or departure from established practice, and is non-routine in nature.

h) The amount of autonomy that staff, especially, frontline staff have over their work and how they do it (how much freedom they have to make decisions on their own; how much control they have over their work; and how much influence they have to shape the way services are delivered).

In this section, some definitions of organizational culture were explored, some of the major criticisms of organizational culture studies were discussed, and the particular interpretation of organizational culture that was deployed in this research project was articulated. The next section relates organizational culture to hybridity and shows the relevance of organizational culture to a research project about hybrid organizations (social enterprises).

1.3.4 Hybridity and Organizational Culture

This section outlines some recent debates about the role of organizational culture in healthcare provision and relates hybridity to organizational culture.

As an organizational form, hybridity affects many aspects of an organization. One aspect of an organization that is affected by a hybrid organizational form is its culture. Organizational culture, in turn, affects the performance of the organization (West et al., 2014; Acar and Acar, 2012; Hunt et al., 2012; Mannion et al., 2010; Naor et al., 2008; Scott et al., 2003; Mannion et al., 2005). Gregory et al. (2009) state that 'the very nature of the healthcare delivery process requires empathy, compassion, and the development of nurturing relationships between caregivers and patients' (p. 674). The importance of values such as empathy, compassion, and

equity to the culture of healthcare provision and the consideration that hybridity may influence how successfully these values can be practiced in healthcare provision suggests that organizational culture and hybridity in health care provision ought to be studied together.

British health care policies from 1998 onwards have stressed the importance of cultural change in the NHS. Scott et al. (2003) suggest that the early indications of the concern with NHS organizational culture appeared in debates on clinical governance. In the last two and a half decades, strategic policy documents of the NHS as well as the influential Kennedy (2001) report as expressions of increasing political concern about culture and the necessity for cultural changes in the health care system.

Davies et al. (2000) trace the debates on cultural change to policy reforms in the NHS initiated in the 1980s. The 1980s reforms recommended by Sir Roy Griffiths resulted in the introduction of general management principles in hospitals. New resource management initiatives were introduced that required clinicians to be involved in budgeting processes. The 1990s saw market reforms which resulted in the separation of the functions of purchaser and provider. A continuous theme running through all these changes is the attempt to increase management and accountability in the NHS and to introduce more of a 'business culture' (Davies et al., 2000; p. 112).

Culture came to the forefront of the health care agenda with the election of the Labour government in 1997 (Davies et al., 2000). A report by the Secretary of State for Health 'A First Class Service: Quality in the New NHS (Department of Health, 1998) stated that 'achieving meaningful and sustainable quality improvements in the NHS requires a fundamental shift in *culture*, to focus effort where it is needed and to enable and empower those who work in the NHS to improve quality locally' (paragraphs 5.6). Further, it states, 'We are looking at major cultural change for everyone. There is a need to develop organisations to support a change in culture and to deliver change' (paragraph 5.21).

The present government's encouragement of hybrid organizations in the delivery of health care may be seen as a continuation of the drive to instil a business culture and enterprise values in the NHS. The Department of Health's Guide to the Right to Provide, *Making Quality your Business* (2011), states that 'setting up a social enterprise gives you the freedom to...engage your staff more so that they understand the value of business culture' (p. 12). Jones et al. (2008) found that 'moving out of the public sector and setting up in business is a challenging process, and social enterprises that have done so...have had to undergo a major process of culture change to instil a commercial focus across the organisation' (p. 9). Thus, culture and cultural change are useful concepts for examining the effects of hybridity on health care organizations.

In this section, it was argued that organization culture is highly relevant to a study of hybridity in health care organizations. The next section will try to link culture with performance and argue that culture may affect performance.

1.3.5 Organizational Culture and Organizational Performance

In this section, the literature on the culture-performance link is reviewed and evidence is cited to justify the assertion that organizational culture may affect performance.

According to Prajogo and McDermott (2011), most studies of organizational culture and performance concentrate on two aspects of culture: content, which refers to the types of values and behaviours exhibited by the employees of an organization, and the strength with which those values and behaviours are held by employees. Both content and strength of culture have been hypothesized to affect the performance of an organization. One of the earliest studies in the *culture strength* tradition was by Peters and Waterman (1982); their study 'In Search of Excellence' claimed that a *strong* culture was linked with exceptional financial performance. Deal and Kennedy's 'Corporate Cultures' (1982) also argued that cultural strength had a major impact on an organization's success.

Theories focusing on the content of cultures have linked certain cultural traits with superior performance. One such popular theory was Ouchi's Theory Z (Ouchi, 1981). Ouchi found that certain organizational cultural traits, which he called Theory Z traits, were associated with higher productivity. Denison's study (1984) found that companies which valued and encouraged participation had a return on investment twice that of companies which did not favour participation. Kotter and Heskett (1992) found that firms that emphasized adaptability as a cultural value were strongly associated with superior long-term performance.

Recent studies have investigated the links between organizational culture and performance and found evidence supporting the hypothesis that culture is a determinant of performance. Gregory et al. (2009) examined the relationship between organizational culture and effectiveness in a health care setting and used the Competing Values Framework to assess the effect of cultural values and attitudes on organizational outcomes. The study found positive and significant relationships between 'Group cultures' and 'Balanced cultures' and patient satisfaction (p. 677-679). Stock et al. (2007) investigated the role of organizational culture in reducing medical errors in American hospitals. They observed a positive and significant association between 'Group cultures' and better error reduction outcomes (p. 382-388). They also observed that 'Rational cultures' were found to be positively and significantly associated with higher error reduction outcomes (p. 382-388).

In summary, a number of studies have investigated the links between organizational culture and performance and found considerable evidence that culture may have an influence on organizational performance. However, there is still a need for more empirical evidence to corroborate the relationship and to specify its exact nature and dimensions. As Scott et al. (2003) conclude after a review of culture-performance studies in health care settings, 'The proposition that organisational culture (however defined) and health care performance (in all its variety) are linked has enduring intuitive appeal, but is currently supported by relatively little firm evidence. Considerable conceptual and empirical work remains to be done to provide better-substantiated articulation of what these links might be – and what their implications are for health care policy and management' (p. 115).

The preceding section established the links between culture and performance and argued that culture may have an effect on performance. The next section brings together the three concepts discussed so far - hybridity, equity and organizational culture – and combines them to present the conceptual basis for this study.

1.3.6 Organizational Form, Culture and Performance

In this section, the previously discussed concepts of hybridity, equity and organizational culture are linked together to prepare the conceptual foundation for this research project.

It is hypothesized that organizational form may affect culture.

It has been established earlier that organizational culture may affect performance.

Promoting equity may be viewed as part of the social purpose or the public service mission of an organization delivering public health care services. So, an organization's performance in terms of improving equity outcomes may be conceptualised as part of its overall performance.

The relationship between the key concepts of organizational form (hybrid, public), organizational culture and organizational (equity) performance may be stated as follows: organizational form (hybrid, public) may have an effect on an organization's culture and, thereby, on its equity-related performance. This relationship is depicted visually in the following diagram.

| Organizational Form (Hybrid, Public) | Culture (Goals, Values, Performance Assessment Measures, Decision-making Processes, etc.) | Equity of Access Performance |
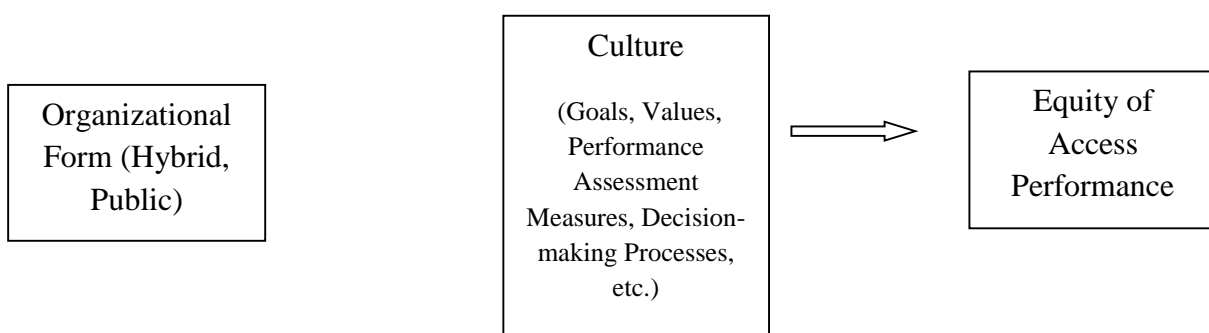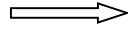
Fig. 1.3. How organizational culture potentially mediates between hybridity and equity

This section introduced the concept of organizational culture and showed the relationship between organizational form, organizational culture and equity performance. The following sections state the formal aims of the research, the research questions and the hypotheses.

1.4. Research Aims and Objectives

This research project aimed to explore the relationship between *organizational form* and *culture*. This research was trying to find out whether an organization's form as *public* or *hybrid* was related to, or affected, its culture around promoting equity in healthcare provision. Since culture may influence performance, and since there is an expectation that public health services will protect and promote equity, organizational cultures around promoting equity in organizations providing publicly financed health services, and changes in these cultures, are of interest.

The first objective of this research project was to compare organizational cultures in *public* (NHS) and *hybrid* healthcare organizations (social enterprises) in terms of their support for promoting equity. This project aimed to find out whether *public* healthcare organizations like the NHS had cultures and working practices that were equally supportive of equity as the cultures of *hybrid* healthcare organizations like social enterprises.

A second objective of this research project was to investigate potential changes in the cultures of healthcare organizations around promoting equity when they changed from *public* to *hybrid* and to explain those changes using theories of organizational behaviour.

1.5. Research Questions and Hypotheses

The specific questions that this research tried to answer were:

1. Does *organizational form* (hybrid, public) have an effect on *organizational culture* around promoting equity in public and hybrid organizations providing publicly financed health services? In other words, are there systematic differences in the cultures of *public* and *hybrid* healthcare organizations in terms of their support for equity?

2. As healthcare organizations change from *public* to *hybrid*, does their culture around promoting equity in service provision change, and in what direction (does cultural support for equity increase or decrease)?

It was hypothesized that the organizational cultures of hybrid organizations may differ in their supportiveness for equity from the organizational cultures of public organizations.

The null hypothesis for the research project was

H_0: The organizational cultures of hybrid and public organizations are equally supportive of equity.

The alternative hypothesis was

H_1: The organizational cultures of hybrid organizations differ from the cultures of public organizations in their supportiveness for equity.

This section stated the aims and objectives of the research, the research questions, and the hypotheses.

1.6. Structure of the Thesis

Chapter two provides an exposition of New Public Management (NPM) and a brief historical overview of NPM-driven changes in the English National Health Service. In this chapter the theoretical framework underlying this research project is explained. Chapter three presents a literature review of the organizational factors that influence the ethical and equity culture of organizations. Systems and mechanisms that affect the ethical cultures of organizations in important ways are discussed and analysed through the use of concrete examples. Chapter four describes the methodology employed in this research project. This chapter provides an overview of the diversity of methodological approaches applied in studies of organizational culture, presents the justifications for the methodological choices that were made in this research project and, finally, articulates the mixed methods research design used in this research project in detail. Chapter five presents the statistical analyses and the results. Chapter six discusses the findings from the statistical analyses and suggests some practical implications of these findings for NHS and Social Enterprise healthcare provider organizations. This chapter describes the major organizational changes that have taken place in the Social Enterprises, examines the impact these changes have had on the equity-supportiveness of their organizational cultures, and unpacks their ramifications for the future provision of public services.

Chapter 2: New Public Management and the Marketisation of the English National Health Service

This chapter aims to explain the theoretical framework underlying this research project. The first section outlines the paradigm of New Public Management that has been highly influential in public administration and policy-making circles in the United Kingdom in the last three decades. The theoretical arguments for and against New Public Management principles are presented. The next section sets out two key themes of New Public Management - marketisation and privatisation. After this some of the risks to equity from the spread of New Public Management ideas are discussed. The next section examines the marketisation of public health services in England in detail. It begins by defining marketisation and goes on to describe the history of marketisation in the English NHS in the last two decades. In this section, the relationship between the marketisation of public health services and the advent of social enterprises in public service delivery is articulated. It is argued that the accelerating marketisation of public health services has been responsible for the increase in interest by

policy-makers in the social enterprise model, and the encouragement given to Social Enterprises to provide public services.

2.1 New Public Management

New Public Management (henceforth, NPM) has been the most influential conceptual framework in the administration of public services in the last three decades (Leech, 2013). The impact of NPM ideas on welfare services, in particular, education, health and social care has been particularly noticeable (Blomqvist, 2005).

Some of the key themes of NPM are:

a) Disaggregation of Public Sector Units: NPM favours breaking up huge public sector monoliths into smaller units to make them more efficient and accountable (Falconer, 1997).

e) Greater Competition in Public Service Provision: A central idea in NPM is that the allocation of resources is best done by the free market, not the government (Falconer, 1997).

f) Private Sector Styles of Management: NPM views the private sector (or business) as an exemplar of efficiency, and advocates the adoption of business principles or private sector management practices as the key to improve efficiency in the public sector. (Falconer, 1997).

NPM ideas have their roots in neo-liberalism, a strain of conservative political thought that has gained ground in policy circles since the 1960s, and neo-classical economic theories (Blomqvist, 2005).

Neo-classical economists extol the virtues of the private sector and the free market, and see in them an answer to the weaknesses of the public sector (Keune et al., 2008). Competition in the pursuit of profit in the free market, these economists argue, is the engine which drives improvements in effectiveness, efficiency and economy (the 3E's) in the private sector; the absence of this vital life force is claimed to be the chief cause of the malaise in the public sector (Ironside and Seifert, 2004). Profit-seeking competition in a free market is, therefore, offered as the solution to the ills of the public sector (Ironside and Seifert). The neo-classical economic position may be encapsulated in the phrase: 'less government and more market' (Petersen and Hjelmar, 2013; p. 5).

The next two sections discuss two of the more contested developments under NPM – the creation of more competitive markets in public healthcare and the privatisation of public health services.

2.1.1 Free Market Competition

A fundamental premise of neo-classical economics is that competitive and free markets lead to better outcomes than monopolistic ones (Brereton and Gubb, 2010; also, Hansen, 2010). In a free market, competition and the pursuit of profit motivate private organizations to constantly strive to improve the quality of their products and services, and to lower their costs because if they don't they will lose to and be replaced by better-performing organizations (Ehsan and Naz, 2003).

The provision of public services is often characterised by a monopoly exercised by the state (Ehsan and Naz, 2003; also, Petersen and Hjelmar, 2013). According to neo-classical economic theory, the allocation of resources in a monopolistic market is sub-optimal (Ehsan and Naz, 2003; p. 34), indicating inefficiency and waste of resources. Neo-classical economists argue

that since public sector organizations do not face the pressures of competition, they lack the motivation to improve the quality of their services or to lower costs (Ehsan and Naz, 2003). Their prescription is, thus, to open up the public sector to competition between various service providers (Hansen, 2010; also, Ehsan and Naz, 2003; and Blomqvist, 2005). Darwinian competition for the custom of service users, it is argued, will weed out poorly performing providers, leaving only the highly performing providers. The result will be an improved overall quality of provision (Mays et al., 2011; also, Musgrave, 2010).

Competitive markets in the NHS are also expected to increase equity, according to some readings of neo-classical economics (Brereton and Gubb, 2010). It is argued that inequity already exists in the public sector where equality is expected to prevail. There is variation in the quality of care, and there is an association between deprivation and quality of care; the more deprived areas tend to have worse care (Gubb and Meller-Herbert, 2009). Since competitive markets will improve the quality of all services, they will also improve the quality of services in deprived areas, thus, increasing equity (Mays et al., 2011). At present, only those from the middle and upper classes can afford to choose private providers of higher quality than public providers; with competition, this choice will be extended to those who were previously unable to pay for private care, thus, increasing equity (Mays et al., 2011). Le Grand (2007, cited in Gubb and Meller-Herbert, 2009) argues further that in public provision where there is no formal choice, the more advantaged are better able to *negotiate* and *create* better choices for themselves. This inequity, he argues, would be reduced if choice of more providers were offered to the disadvantaged and underprivileged. At present, the choices of the poor are effectively restricted to the most proximate public provider (Gubb and Meller-Herbert, 2009). Offering the poor a choice of private and voluntary sector providers, he claims, will level the playing field between the wealthy and the poor (Gubb and Meller-Herbert, 2009; also, Mays et al., 2011).

2.1.2 Privatisation

Privatisation is another key policy prescription of NPM-based reforms (Colley and Head, 2014; also, Leech, 2013). Neo-classical economic theory provides an argument in support of privatisation on the basis of ownership structure. Those who own the organization, it is argued, are likely to have a stronger motivation to do what is necessary to stay competitive and to avoid the prospect of failure (Petersen and Hjelmar, 2013; also, Pollock and Price, 2011). In respect of ownership structure, public organizations are seen to be suffering from a disadvantage which impairs their competitiveness. Hence, the NPM recommendation is to privatise public services to create the same incentives that promote efficiency in the private sector.

In practice, the terms privatisation and competitive marketisation often converge and overlap. According to Whitfield (2006, p. 4), 'privatisation and marketisation are inseparable, the latter creating the economic and ideological conditions and social relations by which further privatisation is developed'.

The next section argues that the growth of interest in social enterprises is related to, and a consequence of, the increasing privatisation and competitive marketisation of public services.

2.1.3 Competitive markets, Privatisation and Social Enterprise

Since 2002, increasing competition between service providers within the NHS and offering patients greater choice of providers have been key aims of both New Labour and Conservative health policies. The social enterprise model, in particular, has attracted the interest of both Labour and Conservative policy-makers. In 'Equity and Excellence: Liberating the NHS', the coalition UK government then in power declared the ambition of creating 'the largest and most vibrant social enterprise sector' in the world (Department of Health, 2010; p. 36). Through the 'Right to Request' initiative, parts of the English NHS were encouraged to spin out and become independent providers of services, and to adopt the social enterprise organizational model. (Mays et al., 2011; p. 24; also, Department of Health, 2011).

The creation of social enterprises through the 'Right to Request' scheme has been described by Peedell (2011) as an act of privatisation. Drawing upon Savas's taxonomy of privatisation strategies, Peedell argues that as the formation of social enterprises by disassociation with the English National Health Service moves services and resources outside the public sector, this externalisation of parts of the NHS is an instance of privatisation by divestment or free transfer (Savas, 2000). Peedell's claim is supported by Kingsley Manning, business director of Tribal Consulting, an organization that provides commissioning support to the NHS (Swindells and Manning, 2010). Encouraging parts of the NHS to break away to form social enterprises, also called 'public service mutuals' (Department of Health, 2014) has had the effect, says Manning, of 'denationalisation through mutualisation' (p. 8), a process that could 'see the transfer of billions of taxpayers' assets to employee controlled businesses' (Swindells and Manning, 2010; p. 8).

The next section articulates some of the risks that NPM ideas of competitive marketisation and privatisation pose to equity

2.2. New Public Management Ideas and the Risks for Equity

A number of criticisms have been made of the application of NPM ideas in the public health sector. These critiques are founded on the well-known failures of the market in the provision of healthcare (Brereton and Gubb, 2010). In his influential article, Arrow (1963) drew attention to some of the serious limitations of markets in healthcare. Many of these criticisms centre around the concern that competitive marketisation and privatisation may pose a risk to equity, that they may result in inequitable provision of healthcare (Appleby et al., 2003; Barr et al., 2008; Oliver and Evans, 2005).

The first criticism that is made of NPM is that it represents the unqualified application of private sector theories and practices to the public sector (Hannigan, 1998). This critique argues that the public sector is different in important and fundamental ways which render the application of private sector methods inappropriate. The public sector is concerned with promoting certain ends which the private sector is not interested in furthering, ends such as 'the expression of collective choice; citizenship; equity; the meeting of need; and public accountability' (Hannigan, 1998; p. 308). The aim of the private sector is to maximise profit (Bradshaw, 2003; also, Petersen and Hjelmar, 2013). The profit-maximisation goal can lead to inequity if private sector organizations avoid more complex and costly customers (Petersen and Hjelmar, 2013). This is known as *risk selection* (Hsiao, 1994; p. 355). According to Hsiao, for-profit private insurers and Health Maintenance Organizations (HMOs) in the United States selectively target affluent, healthy, low-risk customers. He argues that some of the most vulnerable sections of the population are excluded by the selective coverage offered by for-profit private organizations; those left out include 'the elderly, disabled, the chronically ill, low income, unemployed, workers in the unorganized sectors, and farmers' (p. 355). In 2013, 13.4% of the population of the United States, or 42 million people, had no healthcare insurance at all (Smith and Medalia, 2014). These 'high-risk, high-cost' groups are shunned by the private sector (Hsiao, 1994; p. 355). Often, the only care they receive is from the public sector. 'No nation,' says Hsiao, 'has been able to regulate this risk selection effectively' (p. 356).

Lister's (2012) critique of free markets in healthcare is prompted by ethical considerations. Ethical considerations are important in healthcare (Brereton and Gubb, 2010). Healthcare for all can be considered an indisputable aim of a fair and just society. A just society would not deny a person care because they could not afford to pay for it (Brereton and Gubb, 2010; Gubb and Meller-Herbert, 2009). Free markets clearly cannot deliver on this objective as those with the greatest need for healthcare – the very young, the elderly, and the poor – are very often not in a position to pay the market price (Lister, 2012). Healthcare costs can be quite high, especially, for major illness, and most people would struggle to pay thousands of pounds upfront for a complex surgery (Gubb and Meller-Herbert, 2009). Moreover, it is next to impossible for individuals to predict when they will fall ill or have an accident, or what their healthcare needs will be (Gubb and Meller-Herbert, 2009; p. 28). Thus, ethical concerns suggest reservations about the place of free markets in the sphere of healthcare.

Private markets are critiqued on the grounds that they prioritize paying customers (Lister, 2012). 'A turn to the market, 'claims Bergmark (2008), 'hardly ever sustains earlier levels of access to healthcare and that ability to pay becomes increasingly important (p. 245). The profit motive can induce private organizations to allow patients to pay more to jump queues or to avail additional facilities, creating a two-tier system with faster access and better quality service for those who are able to pay (Dahlgren, 2014). Dahlgren objects to the practice of allowing patients who pay more to receive a superior service, arguing that an offer to pay more to obtain faster access or better service is equivalent to the offer of 'a bribe' (p. 517), and that the acceptance of such a bribe by a healthcare professional amounts to 'corruption' (p. 517). Sandel (2012, 2013) objects on the grounds that permitting access to care and quality of care to be bought and sold can lead to a corrosion of the meaning of public goods and services.

Critics of NPM argue that private markets do not take into account structural inequalities of power and resource (Musgrave, 2010); markets are neutral towards the fact of unequal starting positions (Sandel, 2012, 2013; Gubb and Meller-Herbert, 2009); markets are not concerned with ensuring justice and fairness of outcomes (Gubb and Meller-Herbert, 2009): 'A market outcome may well be 'optimal' in terms of allocative efficiency, but deplorable in terms of equity' (Gubb and Meller-Herbert, 2009; p. 26). Private markets increase existing inequalities as they have the effect of redistributing economic resources away from the poor towards the wealthy (Greer and Doellgast, 2013). Thus, their use in the public sector leads to the disorganization and weakening of socially protective and redistributive institutions. According to Musgrave (2010), the application of NPM ideas has had a corrosive effect on the 'protections and defences constructed in post-war welfare capitalism against the rigours, vagaries, demands and inequalities of the market and the unconstrained powers of capital' (p. 9).

A fundamental premise of private market economics is free choice – that consumers choose goods freely (Musgrave, 2010). Choice is problematised by critics who argue that greater choice could widen health inequalities. Mays et al. (2011) suggest that wealthier, better educated groups are able to make better use of the available choices and derive greater advantage from them (also, Fotaki, 2008). 'The more complex a health system is to access and

navigate,' states Leech (2013; p. 166), 'the more likely it would be that the 'sharp-elbowed', well-educated and more able members of society will prevail, leaving a 'health underclass' languishing in their wake as victims of the market'.

This section described the political ideologies shaping the organization of healthcare in the UK and some of the issues stemming from recent trends in public administration. The next section defines the term *marketisation* and provides a brief historical overview of market-oriented reforms in the English NHS in the last three decades. The last section establishes the link between marketisation and the emergence of social enterprises in the healthcare market.

2.3. Marketisation of the English National Health Service

2.3.1 Definition of Terms

In this section, the term *marketisation* is defined. Brennan et al. (2012) define the term *marketisation* to mean 'government measures that authorise, support or enforce the introduction of markets, the creation of relationships between buyers and sellers and the use of market mechanisms to allocate care' (p. 379). They articulate the different forms that marketisation may take: the contracting out or outsourcing of public service delivery to private for-profit and not-for-profit providers, the encouragement of self-financing or out-of-pocket payments by service users, mandating the need to make private provision for risks, for example, by taking out private insurance, etc. (p.379).

Mackintosh (2003) defines *marketisation* as 'the creation of market payment and incentive systems in public provision' (p. 4). She identifies several features of a marketised health care system:

a) 'the increasing provision of health care services through market relationships to those able to pay;

b) the associated investment in and production of those services for the purpose of cash income or profit;

c) an increase in the extent to which health care finance is derived from payment systems based in [on] individual payment or private insurance (p. 4).'

2.3.2 Marketisation of the English NHS: 1991 – Present

The last twenty years have seen the NHS become increasingly marketised, with the pace increasing in the last decade (Krachler, 2013; p. 3). This section provides a historical overview of the marketization of the English NHS from 1991 to the present. This section is divided into two sub-sections. Drawing upon the work of Mays et al. (2011), the first sub-section traces the history of market-oriented reforms in the English NHS from 1991 – 2010. The second sub-section discusses the process of marketization under the coalition government from 2010 to the present.

The idea of introducing market-oriented incentives into the NHS came from the work of the American economist Alain Enthoven. Enthoven's ideas had a strong influence on the Conservative Thatcher government, and were incorporated into government policy. The aim of these changes was to make the NHS more efficient and responsive to the needs of patients while also preserving the principle of universal health care that was financed centrally from taxes and was free at the point of need (Mays et al., 2011; p. 2).

The plan for introducing market-based changes to the NHS was announced by the Conservative government led by Margaret Thatcher in the White Paper *Working for Patients* (Department of Health (1989). This White Paper presented proposals for creating an internal market within the NHS. These proposals came into effect with the passing of *The NHS and Community Care Act 1990*. The internal market became operational from April 1991(Mays et al., 2011; p. 2).

The main change brought about by the new law was to separate the roles of purchaser and provider within the NHS. District Health Authorities (DHAs) became the principal *purchasers*. DHAs received funding based on the needs of the populations that they served, and were tasked with buying hospital and community healthcare services for this population. In theory, they could buy healthcare services from any provider, whether public, private or voluntary. In practice, however, most of the services provided under the NHS were purchased from the public sector (Mays et al., 2011; p. 3).

The *providers* under the new dispensation (i.e., acute hospitals and other providers of NHS services) adopted the new organizational form of *Trusts*. They became statutory corporations independent of the DHA. Trusts entered into contracts with the DHA to perform a certain amount of work. Trusts negotiated the prices for this work with the DHA and received funding according to the amount of work they could secure from the DHA. The theoretical argument ran thus: since the DHA could contract the work from any provider - public, private or voluntary - the public providers had an incentive to minimise costs and maximise quality in order to win these contracts (which were necessary for their financial viability) from the DHA (Mays et al., 2011; p. 3).

Another change introduced by the new law was that General Practices (GPs) were offered the role of *purchaser*. GPs were given the option of receiving funding and becoming *Fundholders*. They could choose to have their own budgets to purchase certain services (non-emergency hospital outpatient and elective surgical, diagnostic and pharmaceutical care) for their patients (Kay, 2002).

Due to the close contact between GPs and their patients, it was thought that GPs were well-placed to take on the role of advocates for their patients. Due to their detailed knowledge of their patients' needs, GPs were encouraged to take on the responsibility of providing for their patients' needs by negotiating their own contracts with secondary care providers. In this new role, GPs would have the power to make decisions about how best to allocate their resources

between providers, services and patients to provide the maximal benefits to their patients. Any surpluses generated by more cost-effective ways of working could be retained by the GPs and re-invested in improving services (Kay, 2002).

The preceding paragraphs outlined the early market reforms under the Conservative government (1991-97). The next few paragraphs continue the discussion of market-oriented reforms to the NHS under the New Labour government.

1997 saw the election of a New Labour government. Under the Conservative government, the tendency of market-based reforms had been to encourage competition within the NHS. The New Labour government replaced that with an emphasis on collaboration. The first step of the New Labour government was to remove the internal market (Mays et al., 2011; p. 4).

While removing the internal market, which was viewed as being wasteful and an administrative burden, the New Labour government retained one of its central principles − the separation of the purchaser and provider roles. The term *purchasing* was changed to *commissioning*. This change of terminology was indicative of a change in emphasis from merely purchasing health services from the range of offerings available to a spirit of collaborative working between *commissioners* and *providers* to develop new and improved services to better meet the needs of the local population (Mays et al., 2011; p. 4).

GP fundholding came to an end as it was believed to have resulted in a *two-tier* service. New primary care groups, consisting of groups of local GPs, were formed. Over time, these primary care groups became formalised as statutory organizations called *Primary Care Trusts* (PCTs). The task of commissioning health services at a local level gradually passed from the DHAs to the PCTs (Mays et al., 2011; p. 5).

The New Labour approach was similar to that of the Conservatives in decentralizing responsibility for the purchasing and organization of healthcare to primary care providers.

However, the emphasis of New Labour's first term in government, and, especially, of Frank Dobson's tenure as the Secretary of State for Health, was to ensure uniform nationwide standards of quality and an active discouragement of competition between providers (Mays et al., 2011; p. 5).

The drive to ensure high nationwide standards of quality led to guidelines in the form of National Service Frameworks (NSFs) which set out the requirements for a good quality service for various health conditions and patient groups. These guidelines were based on the latest evidence and consensus among professionals, and were widely adopted by both commissioners and providers (Mays et al., 2011; p. 5). Another New Labour initiative aimed at standardising quality of care across providers was to set national-level targets (for example, for reducing waiting times) (Stevens, 2004).

The New Labour government kept a tight rein on NHS finances as the previous Conservative government had done. The tight control on NHS spending continued till 2000. In 2000, there was a substantial increase in the NHS budget after Tony Blair announced that per capita spending on the NHS would rise to match the EU average (Mays et al., 2011; p. 5).

1999 saw the devolution of responsibility for NHS policy in Wales and Scotland to the Welsh Assembly and the Scottish Parliament respectively. In England, the Labour government embarked on a programme of investment and reform to the NHS, particularly, with a view to delivering on the 1997 election promises of reducing waiting times. The focus of English NHS policy at this time was on ensuring that the additional resources for the NHS were translated into improved outcomes (Mays et al., 2011; p. 5-6).

The early New Labour years were a period of top-down policy-making and the setting and enforcement of national-level targets (Stevens, 2004). However, by 2002, this *command and control* approach was felt to have exhausted its usefulness (Mays et al., 2011; p. 5). Ministers and their advisors felt the need for other policy instruments to drive further improvements in NHS performance (Mays et al., 2011; p. 5-6).

There was a concern among policy-makers that the boost in NHS spending would not, by itself, lead to better outcomes. There was a fear of sub-optimal utilisation and wastage of the additional resources given to the NHS, and a desire to ensure that the increase in funding was matched by a proportionate improvement in outcomes. It was felt that new measures were needed to derive the maximum possible benefit from the increase in NHS spending (Mays et al., 2011; p. 5-6).

To make the most effective use of NHS resources and to meet the growing expectations of patients and the public, it was thought necessary to return to the earlier idea of promoting competition among providers of services (Stevens, 2004). Thus, behind the re-introduction of market-based reforms by the New Labour government was the desire to ensure that the substantial increase in NHS funding got translated into significantly improved outcomes (Mays et al., 2011; p. 5-6).

New Labour brought back market-based solutions in a slow, evolutionary, incremental way rather than a sudden dramatic launch of full-blown marketisation (Mays et al., 2011; p. 6). As mentioned earlier, Primary Care Trusts (PCTs) were formed in 2002 and were given the task of commissioning services for a geographically-defined population (Walshe et al., 2004). PCTs constituted the commissioning (or demand) side of the market (the providers, i.e., hospitals, mental healthcare providers and community healthcare services constituted the supply side of the market). PCTs were assigned budgets in proportion to the needs of the population that they served (Mays et al., 2011; p. 6). Further decentralization of financial control took place with a new initiative called *Practice-based commissioning* (Mays et al., 2011; p. 7). Under this new scheme, PCTs had to devolve part of their budgets to GPs. The intention was to give GPs the financial muscle to directly shape the provision of local services. In principle, GPs had financial autonomy over their own budgets; however, in practice, their spending was overseen by the PCTs who retained responsibility for drawing up the contracts, and who were accountable for spending by the practice-based commissioners under them. In 2006, there was a major consolidation and rationalization of PCTs: the number of PCTs fell from 303 to 152. After the

reorganization, many PCTs became co-terminous with, i.e., shared geographical boundaries with, local authorities (Mays et al., 2011; p. 7).

There were some continuities and some departures in New Labour's approach to GP-led commissioning. Whereas GP fundholding under the Conservatives was strictly voluntary, New Labour's PCTs had, at least, nominal involvement of *all* GPs. New Labour valued the advantages of GP-led commissioning and wanted the patients of all GPs, even those who did not subscribe to the idea of GP fundholding, to benefit. In the New Labour model, all GPs were, at least, in principle, represented on the professional executive committee of the PCT. This was a key difference between New Labour policy and the earlier Conservative policy (Curry et al., 2008).

At the same time, there were some lines of continuity in New Labour's introduction of *practice-based commissioning*, where there was some degree of voluntarism and flexibility. Though, in principle, all PCTs were required to implement it, the adoption of this scheme was mixed, with some PCTs implementing it more energetically than others. Enforcement was more relaxed, in particular, for practice-based commissioning by practices within PCTs, and a spirit of voluntarism prevailed (Curry et al., 2008).

With a view to shorten waiting lists, the New Labour government introduced NHS diagnostic and treatment centres in 1999. These were 'stand-alone centres on NHS hospital sites specialising in routine diagnostics and high volumes of low-risk, straightforward operations that did not require hospital admission' (Mays et al., 2011; p. 7). In another significant market-oriented reform by the New Labour government, this provider role was extended to nationally commissioned surgical treatment centres run by private, for-profit organizations (Mays et al., 2011; p. 7).

These private or so-called *Independent Sector Treatment Centres* (ISTCs) added extra capacity to the NHS and increased the scope and speed of elective surgery. What was noticeable about this reform and what distinguished it from earlier reforms, however, was that private sector

providers were now being seen as a credible alternative to traditional NHS providers. This move showed a serious intent on the part of the New Labour government to facilitate greater competition between providers of NHS services (Mays et al., 2011; p. 7).

Increasing patient choice was a key element of the market-based reforms brought in by New Labour. *The NHS Plan* (Department of Health, 2000) had given patients the ability to choose the dates and times of their hospital appointments. This was aimed at giving patients greater choice and convenience. Patient choice was extended by the '*Delivering the NHS Plan: Next steps on investment, next steps on reform*' (Department of Health, 2002), which offered patients who had been waiting for more than six months to be treated by the NHS the option to be seen by an alternative private provider. This, it was hoped, would both make better use of existing capacity and reduce waiting times (Department of Health, 2002). Both patient choice and provider competition were furthered by this initiative.

More support for the involvement of the private sector in the provision of public health care services came with '*The NHS Improvement Plan: Putting people at the heart of public services*' (Department of Health, 2004). Till then, the main argument for allowing the private sector within the NHS had been to make better use of existing capacity, speed up treatment and reduce waiting times. This paper, however, argued that the private sector could also play a key role in increasing choice for patients, increasing efficiency, improving quality and making services more responsive to patients (Mays et al., 2011; p. 7).

The agenda of patient choice, plurality of providers and competition was given impetus by the requirement from January 2006 that NHS patients be 'offered a choice of five providers at the point of referral, of which at least one had to be from the independent sector' (Mays et al., 2011; p. 7). Patient freedom to choose providers was further extended in 2008. Hitherto, the choice of private sector providers had been limited to certain nationally approved Independent Sector Treatment Centres and providers. From January, 2008, patients could choose any private sector provider that met NHS eligibility criteria around standards and costs (NHS Choices, 2014; NHS Brand Guidelines, 2011).

Increased patient choice went hand in hand with more choice for GPs who were given the benefit of a new electronic referral and booking system called *Choose and Book*. To support patients in choosing between providers, the government made significant investments in improving the information base about providers and developing comparable indicators of quality of care (Mays et al., 2011; p. 10).

The government wanted to reward healthcare providers according to the amount of work they did. So, it introduced the idea that money would follow the patient. The thinking was that this would give providers an incentive to become more efficient and to increase the number of patients that they treated. To put this into practice, a new activity-based system of payment to hospitals called Payment by Results (PbR) was introduced in 2003 (Mays et al., 2011; p. 7).

In the Payment by Results (PbR) system, a national list of prices was drawn up for various 'health resource groups' (Mays et al., 2011; p. 7). Health resource groups are 'standard groupings of clinically similar treatments which use common levels of healthcare resource... HRGs help organisations to understand their activity in terms of the types of patients they care for and the treatments they undertake. They enable the comparison of activity within and between different organisations and provide an opportunity to benchmark treatments and services to support trend analysis over time. HRGs are currently used as a means of determining fair and equitable reimbursement for care services delivered by providers. Their use as consistent 'units of currency' supports standardised healthcare commissioning across the service' (Health and Social Care Information Centre, 2014).

The prices for each health resource group were fixed and were calculated on the basis of average costs for each health resource group (Mays et al., 2011; p. 7). PbR commenced in 2003. Initially, higher-performing NHS Trusts called Foundation Trusts were moved to the new system. The aim was that, eventually, all NHS-activity would be paid for using these fixed prices or *standard tariffs*, as they were also called (Mays et al., 2011; p. 7-8). PbR was progressively introduced in elective care and emergency care. By 2006/7, the new system was

fully operational and covered inpatient care, outpatient care and Accident and Emergency attendances. There were, however, a few exceptions to PbR: some aspects of acute hospital care (critical care), mental health care, community health services, ambulance services and primary care were excluded (Mays et al., 2011; p. 7-8). In 2009-2010, out of the total expenditure on the English NHS of £105 billion, PbR accounted for only £26 billion (House of Commons Health Committee, 2010).

Whereas in the 1990s internal market under the Conservatives, prices were negotiated locally between DHAs and providers, and were variable (thus, allowing competition between providers on the basis of price), the New Labour market did not allow price-based competition. Prices were fixed (all providers received the standard tariff set for that service by the NHS), and providers competed and were awarded contracts on the basis of quality, not price. This was true, at least, for those services which were paid for under the PbR system. Thus, New Labour policies used patient choice of provider and competition in a fixed-price market as tools to sharpen the incentives for providers for increasing efficiency, quality and responsiveness to patient needs (Mays et al., 2011; p. 10).

Another significant market-oriented reform introduced by the New Labour government was the encouragement of Foundation Trust (FT) status for most NHS hospitals. From 2003, better-performing NHS Trusts could choose to apply for Foundation Trust (FT) status. Foundation Trusts were non-profitmaking, public benefit corporations (Mays et al., 2011; p. 8). FT status gave an NHS provider organization greater financial autonomy and operational control (NHS Foundation Trust Directory, 2014; Foundation Trust Network, 2014; Great Ormond Street Hospital for Children NHS Foundation Trust, 2014). FTs were still a part of the NHS. Unlike ordinary NHS Trusts, however, their greater freedoms included being able to borrow and raise capital from the private sector (up to limits set by the regulator) and to enter into joint ventures with private sector organizations. Initially, all NHS Trusts were expected to progress to FT status by 2014 (Mays et al., 2011; p. 8). However, some have struggled to do so. It is now expected that the process will be completed in the next three to five years (Foundation Trust Network, 2014).

The internal market implemented by the earlier Conservative government lacked adequate independent regulatory mechanisms to oversee the performance of the players in the health care market and to curb abuses (Mays et al., 2011; p. 10). The New Labour era saw the establishment and growth of several independent healthcare regulators to oversee different aspects of healthcare provision. (Thorlby and Maybin, 2010).

An independent economic regulator called Monitor was established in 2004 to oversee the performance of Foundation Trusts. A key difference between FTs and ordinary NHS Trusts was that FTs were no longer directly accountable to the Secretary of State for Health (as ordinary NHS Trusts were) (Mays et al., 2011; p. 8). The creation of FTs severed the link of direct accountability to the Secretary of State and replaced it with local ownership and governance arrangements (Mays et al. (2011), p. 10; Foundation Trust Network, 2014). Thus, there was a need for a new body to regulate the performance of FTs, and Monitor was created for this specific purpose (though in recent times its role has been widened considerably) (Monitor, 2014). Monitor licenses FTs and other health care providers, ensures compliance with regulations, promotes fair competition between providers and prevents abuses of the system (Mays et al. (2011), p. 10; Foundation Trust Network, 2014).

The New Labour government had established a regulatory body to ensure high standards of clinical quality before the re-introduction of market-oriented reforms. The Commission for Health Improvement came into being in 2000 to oversee the quality of care provided by NHS providers and to identify and address any areas of concern. In 2004, the Healthcare Commission replaced the CHI and assumed responsibility for inspecting quality of care and making sure that NHS and private sector providers were meeting the desired quality and safety standards. In 2009, the Healthcare Commission was merged into the Care Quality Commission (CQC). The CQC took on the roles and powers of its predecessors, and is currently the regulatory body responsible for holding all health care, mental health and social care providers, public and private, in England to account for meeting clinical quality standards (Mays et al., 2011; p. 8).

As stated earlier, the introduction of these market-oriented reforms did not occur suddenly or overnight. It was a gradual, incremental process driven by pragmatism (Mays et al., 2011; p. 6, 8). While the individual elements of the reform programme were introduced piecemeal, it was presented as a coherent set of measures in 2005. In *Health Reform in England: Update and Next Steps* (Department of Health, 2005), these inter-locking and mutually reinforcing components were woven together into a coherent narrative of marketisation intended to 'embed within the healthcare system incentives for continuous improvement in quality, health and health outcomes, and value for money' (Department of Health (2005; p 15). The stated aims of this programme of marketisation were: a) increasing efficiency and getting better value for money, b) improving quality of care and the patient experience, and c) reducing health inequalities (Mays et al., 2011; p. 8).

This section outlined the market-oriented reforms under earlier Conservative and New Labour governments. The direction of the earlier reforms has been continued by the current coalition government, however, at an accelerated pace towards full marketisation (Krachler, 2013; p. 3). The move towards a full-fledged market in healthcare has acquired momentum with the passing of the Health and Social Care Act 2012. The next section sets out the changes brought about by the new Act.

2.3.3 Marketisation of the English NHS: 2010 – Present

Under the Health and Social Care Act 2012, the principal responsibility for commissioning health services lies with Clinical Commissioning Groups (CCGs). CCGs are led by General Practices (Department of Health - Health and Social Care Act 2012: Fact Sheets - Clinically-led Commissioning Fact Sheet, 2012). CCGs may also include hospital consultants, nurses, other health practitioners and lay people (Krachler, 2013; p. 9). GPs, it is thought, are closest to their patients and local communities and know best how money should be spent (Department of Health Fact Sheet - Clinically-led Commissioning, 2012).

The aim of the Act is to empower front-line clinicians who know what is best for their patients to shape the provision of local care. Enabling local clinicians to make decisions about local services, instead of these decisions being made by some far-off, remote bureaucrat, it is thought, will enable the most effective utilisation of NHS resources (Department of Health Fact Sheet - Clinically-led Commissioning, 2012). CCGs will have a direct commissioning role, so, they will be able to decide which services to provide, and who to contract them from. (Tailby, 2012). Where this Act differs from earlier approaches to GP-led commissioning, such as practice-based commissioning, is that this will be a universal system involving all GPs, and GPs will hold real budgets (Department of Health Fact Sheet - Clinically-led Commissioning, 2012).

CCGs will be supported in their commissioning tasks by the NHS Commissioning Board (Department of Health Fact Sheet - Clinically-led Commissioning, 2012). Commissioning Support Services (CSSs) will be set up to support and advise CCGs during the initial phase as they grow into their new roles. These CSSs will initially be a part of the NHS Commissioning Board but will gradually become independent commercial organizations, selling their services to CCGs. CCGs can choose to outsource their commissioning duties to these private commercial CSSs (Unison, 2012; p. 2). According to the King's Fund, CCGs are likely to require a lot of support in performing their commissioning duties, and many CCGs may opt to buy this support from private or voluntary sector organizations (The King's Fund, 2011).

In the past, the income that an NHS Trust could raise from charging private patients was capped. Previously, a Trust could not earn a higher proportion of its total income from privately paying patients than it did in the financial year 2002-03 (Wiltshire Council Briefing on The Health and Social Care Act 2012, 2012). Private income for NHS Trusts averaged about 2%, though there were significant geographical variations (The Guardian, 2014). The Act relaxed the upper limit; now an NHS Trust can earn up to 49 % of its income by charging private patients (Unison, 2012; p. 3).

The Act strengthens the role of choice and competition. Choice of provider and competition, it is argued, will lead to better health outcomes, higher patient satisfaction and better hospital management (Department of Health - Health and Social Care Act 2012: Fact Sheets - Choice and Competition Fact Sheet, 2012). The Act has extended choice for patients under the *Any Qualified Provider (AQP)* scheme. Patients will now be able to choose from a greater range of private and voluntary sector organisations for particular types of care (Unison, 2012; p. 2).

The Act attempts to create a level playing field to ensure fair competition between healthcare providers (Department of Health Fact Sheet - Choice and Competition, 2012). CCGs can no longer consider NHS providers as their preferred provider (Unison, 2012; p. 2). Monitor has been given the task of ensuring that private and voluntary sector providers are not disadvantaged and are able to compete fairly with NHS providers for NHS contracts (Monitor, 2014).

According to the King's Fund, these 'reforms may, over time, result in an increase in the proportion of NHS-funded care delivered by private and voluntary sector organisations; this will depend on both commissioners and patient choice' (King's Fund, 2011).

This section described the history of marketisation in the English NHS. In the next few paragraphs, the role of marketisation in spurring the creation of social enterprises is described.

2.3.4 The Marketisation of the English NHS and the Role of Social Enterprises

A central feature of marketisation is a mixed economy of welfare provision wherein private and voluntary sector providers operate alongside public sector providers (Powell, 2007). Since 2002, increasing competition between service providers within the NHS and offering patients greater choice of providers have been key aims of both New Labour and Conservative health policies. Increasing the diversity of providers within the healthcare market by encouraging the

involvement of private and third-sector organisations was seen as an important way to achieve these aims (Allen and Jones, 2011; p. 16).

While both private and third-sector organisations have been encouraged to play a greater role in public service delivery, particular emphasis has been given to supporting voluntary sector providers to enter the market for public service delivery and to compete for public contracts (Hall et al., 2012; p. 733-734). New Labour's reforms specifically required commissioners of NHS services to actively encourage participation from the 'social economy', which includes voluntary groups, charities, foundations, trusts, social enterprises and co-operatives (Department of Health (2006), cited in Allen and Jones, 2011; p. 23).

The social enterprise model, in particular, has attracted the interest of both Labour and Conservative policy-makers; both have been keen to promote this organizational model and create a greater space for it in the delivery of public health and social care services in England. In 2006, a Social Enterprise Unit was set up by the Department of Health to assist the creation of new social enterprises and to support them in entering the NHS healthcare market (Allen and Jones, 2011; p. 23, 24). This Unit was given £100 million in the next four years to strengthen and develop the capacity of social enterprises to fulfil their new role as public sector providers. The Unit provided support to fledgling social enterprises by giving them access to start-up capital, business and legal advice, and training (Allen and Jones, 2011; p. 24). The Unit initiated a pilot of public service delivery through social enterprises called the 'Pathfinder' programme wherein twenty six new and existing social enterprises were given short-term contracts to provide NHS services (Allen and Jones, 2011; p. 24). The government also encouraged existing NHS community healthcare organizations to spin out from the NHS and become social enterprises. (Department of Health, 2007; Tribal Newchurch, 2009).

In this section, the term 'marketisation' was defined, and it was shown that the process of marketisation has encouraged the growth of social enterprises and their entry into the health care market.

Chapter 3: Literature Review of Organizational Factors that Impact on the Ethical and Equity Cultures of Organizations

This chapter discusses the roles of various organizational structures that influence the ethical cultures of organizations. Systems and mechanisms that affect the ethical cultures of organizations in important ways are discussed and analysed through the use of concrete examples. The chapter begins by clarifying the focus of this research project. It is suggested that the focus of this chapter will be on the analysis of structural organizational influences on the ethical cultures of organizations. Next, an overview is provided of the recent trends in organizational research towards identifying and understanding the systemic, organizational influences on unethical behaviour. The subsequent sections of the chapter take up common approaches to building ethical organizational cultures one by one and discuss them in detail.

This chapter is divided into two parts. In the first part of this chapter (sections 3.2 to 3.10), the international business management literature on organizational systems that assist in building an ethical culture is reviewed. The second part (sections 3.11 to 3.13) focuses on the comparable British literature, and particularly concentrates on literature pertaining to the British National Health Service (NHS). The rationale for this twofold division is explained below.

The first part of this chapter (sections 3.2 to 3.10) reviews the international business management literature to draw out useful lessons that could be applied to the task of strengthening ethical behaviours in public healthcare provider organizations in the UK. Since healthcare Social Enterprises are the focus of this research project, and as Social Enterprises attempt to manifest hybridity by combining the best management practices from the public, not-for-profit and the private, for-profit sector, it was thought appropriate that this literature review should also draw upon the best thinking in the international business management sector as well as the public management literature on the best ways to create an ethical organizational culture. There are relevant parallels between the experiences of the NHS and the private, for-profit sector, and useful lessons that the NHS could learn from its private sector counterparts. Some of these are explained below.

While their aims and values may be very different, even private, for-profit organizations struggle to align their daily operational practices with their missions and values. They also wrestle with the challenge of conflicting missions. They also suffer from the consequences of the unethical actions of staff. Conversely, their successes in building ethical organizational cultures (for example, the way in which Levi Strauss Inc. clarified and then practiced its corporate values or Johnson and Johnson's admirable ethical conduct during the Tylenol crisis) have much to teach the NHS. In short, there are many points of overlap between the NHS and the private, for-profit sector.

Therefore, the first part of the literature review aims to extract useful lessons from what international business organizations have learnt about ways of building ethical organizations. The second part focuses directly on NHS provider organizations (including Social Enterprises) and organizational systems for building an ethical and equitable culture of care in public healthcare provision in the UK.

3.1. Clarification of the Focus of this Research Project

This research project did not look at organizational performance itself. It is acknowledged that there was no use in this research project of actual performance data of any kind. The scope of this research project was limited to perceptions of organizational culture around equity. So, this research project does not make any claims about the effects of organizational factors such as leadership, autonomy, performance management systems, incentive systems, etc. (and changes in them) on organizational performance around equity. What this research project does examine is how various organizational factors such as leadership, autonomy, performance management systems, incentive systems, etc. shape the organization's culture, specifically, how they shape the equity-supportiveness of the organization's culture. Thus, organizational culture is being treated in this project as a proxy for organizational performance. It is acknowledged that the implicit premise of this research project is that organizational culture affects performance, therefore, the factors that shape organizational culture are considered to be worthy of study.

It should also be noted that this literature review discusses how various organizational factors shape the organization's *ethical* culture, not specifically the *equity* culture. However, as equity may be seen as part of the ethical culture of an organization, and as no separate literature focusing on equity culture was found, the closest available literature was reviewed.

This section outlined the broad approach to be followed in this chapter. The next section discusses recent trends in organizational research towards emphasizing the organizational bases of unethical behaviour rather than blaming the moral limitations of individuals. The section starts by offering definitions of key terms used in this chapter. It, then, describes the trends in organizational research and the common approaches to building ethical cultures.

Part One

3.2 Bad Apples or Bad Barrels ? Organizational Influences on (Un)ethical Behaviour: An International Perspective

The first structural factor to be examined in this section is the leadership of the organization. Leadership is one of the most important influences on the ethical culture of an organization. The manifold ways in which leaders shape the cultures of their organizations for better or for worse are described. The next section discusses another important structural factor – organizational values – and how they inform an organization's ethical culture. A concrete example is presented of an organization that has placed values at the centre of its ethics strategy. Thirdly, the role of organizational mission and goals is explored. Along with values, mission and goals are one of the most decisive influences on an organization's ethical culture. The ways in which this influence is exercised is mapped out in this section.

The next two sections take up the discussion of some of the most potent tools in the hands of the leadership in moulding the behaviour of employees and directing it towards good or bad – the use of incentives and reward systems, and the role of performance evaluation processes. Fifthly, the need for organizations to articulate their ethical compass, their code of ethics is suggested, along with an analysis of how a code of ethics helps inform and guide an organization's ethical culture. Sixthly, the role of decision-making powers granted to employees in creating an ethical organizational culture is investigated. An example is used to illustrate the ethical hazards of not giving employees sufficient decision-making powers. The last section analyses the various ways in which an emphasis on quality helps strengthen the ethical fibre of an organization. Quality, it is argued, has a symbiotic and synergistic relationship with ethics.

3.2.1 Definitions of Key Terms

Segon and Booth (2015; p. 95) define organizations as 'consciously coordinated entities that exist within identifiable boundaries with specific goals and objectives' (also, see Arrow, 1974; Daft, 2010; Galbraith and Lawler, 1993; Robbins and Barnwell, 2006).

Ethics is a branch of moral philosophy that analyses questions about morality, about what good and bad behaviour mean, about what constitutes right and wrong action (White and Lam, 2000; p. 35). Ethics is an important part of an organization's culture (Sims, 2000; Trevino and Nelson, 1995). Vardi & Wiener, 1996 define unethical behaviour as 'any intentional action by members of organizations that violates core organizational and/or societal norms' (p. 151).

Ahmed and Machold (2004) describe unethical organizations as those 'in which expediency is the standard norm... in which we no longer trust people to tell the truth, honour obligations or act with moral fortitude... profit is the driver: customers remain transactions; employees remain mere tools to increase the bottom line, not partners in business; the environment and ecology are just more burdens requiring minimum compliance; and community stakeholders remain at the farthest stretch of the periphery.' (p. 527-528). Sims and Brinkmann (2003) suggest that there can be, as the Enron case illustrates, a significant divide between what an organization says and what it does. They make a useful distinction between 'a deceiving glossy facade and a rotten structure behind', between surface-level cultural artefacts such as ethics codes, policies, officers, etc. and 'deep culture', which is how the business actually operates (p. 243).

3.2.2 Organizational Influences on Ethical Behaviour

Vidaver-Cohen (1998) defines the ethical or *moral climate* of an organization as 'prevailing employee perceptions of organizational signals regarding norms for making decisions with a moral component' (p. 1213). The norms for organizational decision-making are the commonly practiced and expected ways of making decisions. Policies and procedures signal to employees the norms for making decisions. Prevailing perceptions are the shared views and beliefs about the kinds of behaviour that are expected by the organization. The relationships and interactions between the different aspects of an organization and its moral climate are depicted by Vidaver-Cohen (1998) (see figure 3.1 below):
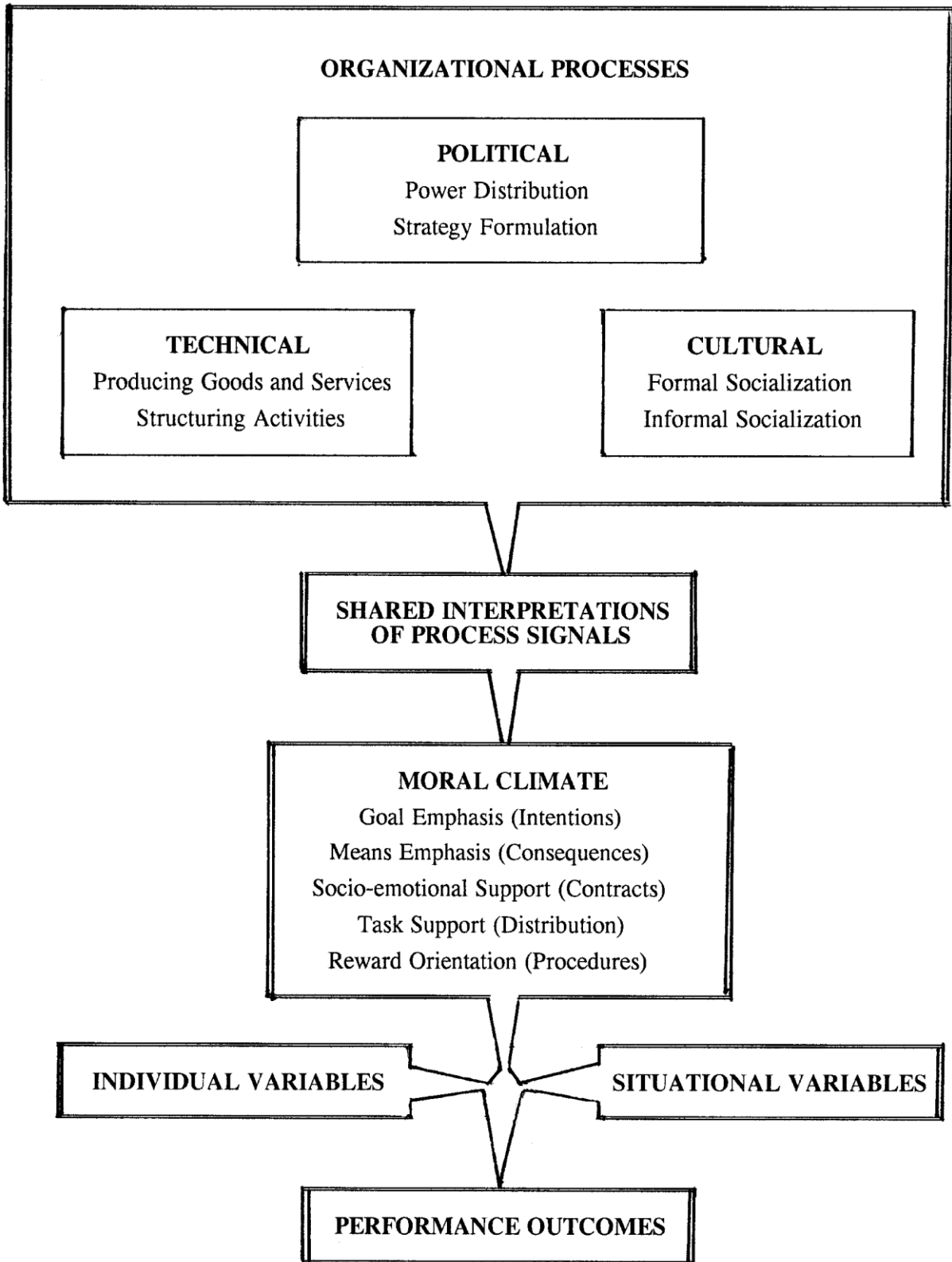
Figure 3.1 Organizational processes, moral climate and performance. Moral climate as an intervening variable that affects performance (Vidaver-Cohen, 1998; p. 1215)

Vidaver-Cohen (1998) clarifies that a moral climate does not *cause* an individual to engage in ethical or unethical conduct. A moral climate does, however, encourage an individual disposed towards ethical behaviour and discourages an individual disposed towards unethical behaviour. A moral climate conveys the shared sense among employees of the behaviour expected by management in that situation (Vidaver-Cohen, 1998).

Organizational researchers examining ethical failures in organizations have broadened their focus and looked beyond the characteristics of the individuals who commit ethical violations to the organizational context that aids or condones such behaviour. Described by Trevino and Youngblood (1990; p. 378) and Kish-Gephart et al. (2010; p. 2) as a move away from the 'bad apples' approach to the 'bad barrels' approach, the organizational context (formal ethical structures and systems, the ethical culture of the organization, etc.) is now regarded by many researchers as a potentially important contributor to unethical behaviour (Key, 1999; Sims and Brinkmann, 2003; Sinclair, 1993; Casey et al., 2001; Lease, 2006; Trevino et al., 1999; Peterson, 2002a, 2002b; Martin and Cullen, 2006; Vardi, 2001; Weber, 1995; Wimbush et al., 1997). These studies follow in the long-standing tradition of research that attempts to link organizational behaviours and performance with organizational culture and climate (Denison, 1996; Schein, 1985, 1996).

White and Lam (2000) argue that unethical behaviour does not take place in a moral vacuum. It takes place within a context which supports the unethical behaviour directly and actively, or indirectly by condoning it, by not speaking out against it, by not disciplining it. The authors argue that silence and passive acquiescence by others who know about the unethical behaviour and, yet, do not protest, amounts to collusion and complicity. In support of this view, Paine (1994) states that 'unethical business practice involves the tacit, if not explicit, cooperation of others and reflects the values, attitudes, beliefs, language, and behavioural patterns that define an organization's operating culture. Ethics, then, is as much an organizational as a personal issue. Managers who fail to provide proper leadership and to institute systems that facilitate ethical conduct share responsibility with those who conceive, execute, and knowingly benefit from corporate misdeeds' (p. 106). White and Lam's (2000) fundamental point is that the ethical or unethical behaviour cannot be attributed solely and exclusively to individuals. Although the decision to behave unethically is, ultimately, an individual's decision, the choices

that individuals make are influenced by the organizational environment they work in. 'Organizational climate,' say the authors, 'shapes individual actions by providing explicit and implicit guidelines of acceptable behavior' (White and Lam, 2000; p. 38); 'There is an interplay between an ethical organizational environment and individual ethical judgments' (White and Lam, 2000; p. 41). Therefore, organizations have a hand to play in facilitating or preventing ethical misconduct. Organizations can either expand or limit the scope for unethical behaviour by the kinds of 'ethical milieu' they choose to foster (White and Lam, 2000; p. 40).

Chen et al. (1997) argue that individual ethical behaviour does not occur in grand isolation. On the contrary, organizations wield a lot of power over individuals and mould their behaviour for better or for worse (Brown, 1987). Unethical conduct, Brown suggests, is not a problem of the individual though, in practice, it is often treated as such (Chen et al., 1997). A common form of ethics training presents individuals with ethical scenarios and offers guidance to assist them in arriving at the right choices. Disciplinary procedures for ethical lapses usually target the individual and rarely question the organizational practices that might have driven the individual to such behaviour.

The premise implicit in both the ethics training and the disciplinary procedures, as Chen et al. (1997) clarify, is that ethical behaviour is essentially a private, personal, intra-individual decision. This view of ethical behaviour, argues Bellah et al. (1991), derives from a wider political and moral discourse centred on an extreme form of individualism. This individualistic philosophy, claim Chen et al. (1997), 'severely inhibits, if not precludes, our ability to understand how individuals find themselves in moral dilemmas in the first place. The ethics problem is not one of individual misconduct so much as it is one of the inadequacy of institutions' (p. 857). The views of Chen et al. (1997) and Bellah (1991) grant recognition to the fact (which is rarely admitted) that ethical dilemmas are, at least partly, creations of organizations, and of organizational policies and practices which place individuals in situations that force them to compromise their ethical values. This perspective has gained ground in the last few years. Several researchers now agree that consideration of (especially) systemic and widespread (rather than isolated) instances of ethical failure require an examination of the organizational context that, at the worst, encouraged and, at the best, tolerated such undesired behaviour (Murphy, 1989; Reidenbach and Robin, 1991; Sims, 1992; Ford and Richardson,

1994; Wimbush and Shepard, 1994). Ethical culture is now accepted to be an important contributor to and explanator of individual ethical behaviour: 'The more ethical the culture of an organization, the more ethical will be an individual's decision behavior' (Chen et al., 1997; p. 856).

Trevino and Brown (2004), arguing against the 'bad apples' theory (the idea that ethical malpractice is the result of the actions of a few guilty individuals, and that if they are identified and removed from the organization, the organization will be ethical again), suggest that individuals are deeply influenced by the organizational context. Most people, they suggest, 'look up and look around, and they do what others around them do or expect them to do' (p. 72). The 'bad apples' theory, they suggest, is based on two faulty premises: a) that the ethical natures of adults are fully formed and unchangeable, and b) that moral decisions are made autonomously, i.e., solely, without external influence, by individuals. Therefore, there is nothing that can be done about immoral individuals (the bad apples) except identifying them and casting them out. Trevino and Brown challenge both these claims.

In response to the first claim, they assert that the moral natures of most people are malleable and capable of development through education and guidance. The potential for the development of moral reasoning in most individuals, they suggest, is not exhausted by the time they reach adulthood or when they join work. Further, the more people wrestle with organizational ethical challenges, under appropriate guidance, the sharper and more nuanced their moral reasoning becomes, with accompanying benefits to their ethical decisions. Research has uncovered that organizations that institute formal and comprehensive ethics programmes tend to encourage more ethical behaviour in their employees. A survey of American companies, the National Business Ethics Survey (Ethics Resource Center, 2003), revealed that in organizations with at least four ethical mechanisms (written standards for ethical conduct, ethics training, ethics advice lines, and systems for anonymous reporting of unethical activities), staff were much more likely to report misconduct that they had observed (78% of staff said that they would report misconduct to management). In contrast, in organizations that had no formal ethics mechanisms, a far small number (50%) said that they would report misconduct). The fewer the ethical mechanisms, the lower was the probability that staff would report ethical malpractice. Thus, formal ethical and legal compliance programmes do have an

observable impact on the ethical thinking and behaviour of employees (Trevino and Brown, 2004).

Questioning the second claim, the authors aver that individuals are not atomised, self-contained, moral entities who make decisions in a moral vacuum. Instead, the reality of organizations, they suggest, is that most people look at people around them and take hints from the behaviour of their leaders and peers in charting their own course of action. The signals that are constantly sent out by leaders about organizational expectations are tremendously powerful in shaping the behaviour of subordinates (Trevino and Brown, 2004). The 'bad apples' theory ignores the influence of these powerful signals and, thus, may constitute an evasion of moral responsibility by those who determine organizational priorities and expectations.

White and Lam (2000) identify a pressing issue that lies at the heart of organizational failures in matters of ethical conduct. Ethics simply isn't a priority for most organizations. It is viewed as being peripheral to the organization's main activity. As Ferguson (1993) put it, 'Most managers saw bottom line, hard business issues as priorities and ethics didn't make the short list (p. 32)'. Citing several instances of systemic unethical behaviour by organizations, Vidaver-Cohen (1998) argues that a common theme underlying these ethical lapses is managerial disregard for 'doing the right thing' (p. 1213). This suggests a need for a radical re-visioning of the role of ethics in organizational life and for a radical re-education of all organizational staff, and the institutionalization of pervasive mechanisms that underscore the central role that ethics plays in all organizational activity.

Paine (1994) makes an insightful point when she suggests that organizational ethical failure is less likely to stem from deliberate managerial intention to harm or defraud customers and more from ignorance of or apathy towards ethical concerns and, crucially, an absence of strong organizational systems to promote ethical behaviour and discipline misconduct. The importance of supporting systems is also suggested by the example of Beech-Nut Nutrition Corporation, a maker of fruit juices, which was found to have misinformed customers by selling '100% apple juice' that was actually just sugar water and chemicals (Paine, 1994; p. 108). The company knew about this for a long time but did nothing about it. When the Chief

Executive Officer raised this issue, he was dismissed as being over-scrupulous. The fraud was detected and the company lost $25 million in the lawsuit that followed. One of the contributory factors to this knowing and wilful organizational ethical violation was that there was no quality control system in the company, no method of testing the purity of the juices, no system to provide incontrovertible evidence that the apple juice was, in matter of fact, mis-labelled. The lack of necessary organizational systems allowed the ethical issue to remain clouded and provided the pretext for executives in the company to turn a blind eye to it (Paine, 1994).

3.2.3 Approaches to Creating an Ethical Culture

In relation to the ethical standards that organizations should aspire to, Paine (1994) suggests that compliance with the law should be considered as a starting point and not the end point. She challenges the fallacy that 'If it is legal, it is ethical' by pointing out that it is legally permissible to sell hazardous products without appropriate warnings and to run sweatshop-like businesses that violate the human rights of employees in some countries (p. 109-110). Merely toeing the legal line is fraught with additional problems: often, managers who are expected to guide employees and support them in adhering to the law have poor understanding of the subtleties and complexities of the law themselves. Clearance from the legal department is not an adequate remedy for managers' lack of understanding as in some known instances the legal offices of organizations have chosen to take a passive stance or acquiesce in wrong-doing by employees. Therefore, argues Paine, compliance with the law should be considered as the floor, the basic minimum, and not the ceiling for ethical behaviour. She claims that 'legal compliance is unlikely to unleash much moral imagination or commitment. The law does not generally seek to inspire human excellence or distinction. It is no guide for exemplary behaviour—or even good practice. Those managers who define ethics as legal compliance are implicitly endorsing a code of moral mediocrity for their organizations' (Paine, 1994; p. 111). In support of her argument, she quotes Richard Breeden, former chairman of the Securities and Exchange Commission, who observed that 'it is not an adequate ethical standard to aspire to get through the day without being indicted' (Paine, 1994; p. 111). Instead, Paine advocates 'a more robust standard' and proposes an 'integrity strategy' to achieve this (p. 111).

Trevino and Brown (2004) recommend that the management of ethical culture be *conscious* and *proactive* (p. 69). Segon and Booth (2013) suggest that ethics ought to be recognized as a strategic function and given the seriousness it deserves. Ferrell et al. (2010) argue that the ethics function ought to be treated as any other function, and that just as employees can be supported to improve their performance in other areas, they can be assisted to behave more ethically. A strong sense of responsibility, Paine (1994) argues, is what characterizes organizations with highly ethical cultures.

According to Kaptein (2011), unethical behaviour is rarely the result of one dysfunctional aspect of the ethical culture of an organization. Ethical misconduct usually occurs when more than one aspect of the ethical culture is out of alignment. Thus, tackling ethical misconduct requires addressing multiple dimensions of the ethical culture.

The influence of organizational structure on ethical behaviour is receiving growing attention (Lindsay et al., 1996; Trevino and Nelson, 1995). James (2000) observes that, often, unethical behaviour in organizations such as lying, cheating and stealing is not due to the moral limitations of the individuals concerned but the result of poorly designed organizational structures which encourage perverse behaviour. As James notes, 'Organizational factors frequently overpower individual motivation (p. 46)'. Gioia (1992) describes how institutional roles or 'scripts' can be powerful enough to corrode the personal ethical values of employees (p. 385). In a study by Badaracco and Webb (1995), business school graduates who had recently joined organizations reported being considerable pressure to act unethically. The pressure stemmed, not from the moral failings of their superiors, but from structural organizational factors. Structural influences on ethical behaviour gain further importance from the finding that the adoption of codes of ethics by organizations has little impact on the ethical behaviour of employees (Rich et al., 1990) and that formal education in ethics is of limited effectiveness in changing managers' attitudes to ethics (Crandall et al., 1996).

As Brytting (1997) suggests, ethical behaviour is influenced by many factors, including everyday practice, the pattern of social interaction, tradition, custom, etc. (p. 663). However, this takes place within a context, and this context is shaped by, what Brytting calls, 'moral

support structures' (p. 663). These moral support structures, argues Brytting, are particularly salient for discussions of ethical behaviour, insofar as they are purposeful creations of the organizational leadership and have received official their backing and approval.

Collins (Collins, 2001; Collins and Porras, 1994) argues that the decisions that matter the most in shaping an organization's culture are the people decisions, the 'who' decisions (Collins, 2001; p. 41 - 42). In crafting an organization's culture, he recommends beginning with people decisions, a principle he describes as 'First who, then what' (Collins, 2001; p. 41 - 64). He claims that nothing attracts the attention of employees as much as people decisions: who gets hired, who gets promoted, who gets fired.

A company praised by Paine (1994) for its ethical approach to doing business was Wetherill Associates, Inc., an American company that made electrical parts for automobiles. Wetherill's approach to ethics was encapsulated in the statement that 'creating a climate that encourages exemplary conduct may be the best way to discourage damaging misconduct. Only in such an environment do rogues really act alone ((Paine, 1994; p. 117)'. This organization was a good example of how structural systems working in unison had resulted in a highly ethical organization culture (Paine, 1994). The corporate ethics officer for the organization was the highest ranking member of staff, the Chief Executive Officer. The CEO, Marie Bothe, believed that it was her responsibility to keep the company focused on 'right action', which she defined as serving their clients. The organization's ethical philosophy, codified in their Quality Assurance Handbook, emphasized serving customers rather than competing with rivals. Wetherill staff even referred customers to competitors on occasion if their products did not meet the customer's needs. Scrupulous honesty characterized the organization's business transactions: it was known to inform suppliers of over-shipments as well as under-shipments; structures that might have created perverse incentives for unethical behaviour such as sales contests to motivate employees to improve their performance or determining compensation on the basis of sales were avoided; even in situations where the company could have got away with inflating prices for auto parts, rigorous honesty was observed (Paine, 1994).

Wetherill recognized the importance of people decisions and ensuring fit with their ethical values (Paine, 1994). While assessing the skills and competencies of potential recruits, their ethical soundness was given equal weight. New hires were informed that 'absolute honesty, mutual courtesy, and respect are standard operating procedure' in Wetherill (Paine, 1994; p. 117). Formal ethical training and support were organized for new hires; some reported a culture shock and experienced challenges in making the transition to the high ethical standards of the organization. Wetherill was a good example of consistency and alignment between organizational structures creating an organizational context supportive of highly ethical behaviour (Paine, 1994).

Some of the mechanisms that can be used to mainstream a focus on ethics include having a written code of ethics, ethics committees, ethics ombudsmen, and equity audits (Buchholz, 1989). Similar frameworks to support the 'institutionalization of ethics' (Segon and Booth, 2013; p. 100) have been proposed by Trevino and Nelson (1995), Driscoll and Hoffman (2000), and Ritchie (1996).

Kaptein (2011) lists some of the essential components of a comprehensive ethics programme: 1) a comprehensive written code of ethics; 2) an ethics officer (referred to in some organizations as a compliance officer or ombudsperson), or ethics office or committee; 3) a formal, structured ethics training programme, supplemented by ongoing information on ethical issues; 4) a designated system to raise ethical issues and report ethical concerns (for instance, a telephone, email, or live chat-based ethics hotline or helpline); 5) organizational policies and systems for the monitoring of performance to detect unethical behaviour, including ethics audits; 6) organizational policies on the investigation of and disciplinary procedures for unethical behaviour; 7) organizational policies to recognise, reward and incentivise ethical behaviour; and 8) pre-employment assessment of the ethical standards and integrity of potential recruits (2011; p. 854).

In order to maintain the effectiveness and relevance of ethical frameworks, they should be revised regularly to keep pace with changes in technology, new laws and regulations, etc. (Trevino and Nelson, 1995; McDonald, 2008).

3.2.4 The Role of Ethics Officers, Committees, etc. in Creating an Ethical Culture

It is acknowledged by organizational researchers that structural elements of the organization have a significant influence on ethical behaviour by employees (Brytting, 1997; Driscoll and Hoffman, 2000). As Segon and Booth (2013) note, 'Without formal mechanisms, ethics strategies are likely to be undermined and staff begin to question the organizational commitment to the process' (p. 113). An important structural mechanism for promoting ethical behaviour is an ethics committee, preferably, one with members who are independent of, and external to, the organization and have expertise in ethics (Segon and Booth, 2013; p. 112; also, see Preston, 1996). Another is the existence of a dedicated ethics officer or team (Brytting, 1997). Segon and Booth observed the absence of structural mechanisms to support ethical behaviour at the hospital mentioned above. There was no ethics officer to monitor and enforce ethical behaviour, nor was there any other structural support for managers, or by managers, in relation to ethical behaviour. While there was an ethics committee, its role was limited to medical and health ethics, and did not extend to organizational or business ethics.

An individual, team or body dedicated explicitly to the resolution of ethical issues and promotion of ethical behaviour (such as Ethics Officers and Ethics Committees) communicates to staff that the organization takes ethics seriously (Brytting, 1997). The Center for Business Ethics (1986) lists some of the functions performed by Ethics Officers and Committees: raising employee awareness of ethics in the specific context of the organization or industry, highlighting common ethical issues that an employee may encounter, increasing employee ability to analyze ethical issues and formulate appropriate ethical responses, improving management to support ethical behaviour, and responding to ethical concerns, warnings and complaints by staff. Brytting suggests that the more resources, power (to impose sanctions, for example) and support from leadership (number of senior staff, for example) that the Ethics Officer or Committee has, the greater the credibility of the organization's commitment to ethics and the more likely that staff will take behave ethically.

Brytting (1997) indicates that such formal support structures are understandable in large organizations with tens of thousands of employees, such as large NHS Trusts. These large organizations usually have separate, dedicated Ethics officers and teams (Equalities Lead, Equality and Diversity / Inclusion Officer, etc. are some of the names given to this role). However, Social Enterprises tend to be smaller organizations (from fifty to a thousand employees), so, the formal structural features found in bigger organizations such as the appointment of an individual dedicated solely to the task of promoting ethics and equity may not always be feasible. In these smaller organizations, the role is often shared by an individual along with other responsibilities, for example, the Head of Clinical Quality will perform this task along with their other primary roles. Brytting's (1997) survey of private firms in Sweden yielded a similar finding. The results of the survey showed that small firms generally did not have a dedicated full-time Ethics Officer. In small firms, it was a very common expectation that the role of Ethics Officer would be discharged by the Chief Executive Officer or a senior member of the management team in addition to their primary responsibilities. The survey found that they devoted, on average, less than a quarter of their total time to their role as the Ethics Lead for the organization. Due to the senior position of the person undertaking this role, they commanded a lot of resources and had access to the necessary information to investigate cases of ethical import. Again, due to their high position in the organizational hierarchy, they commonly had strong decision-making powers and were able to impose substantial sanctions. The survey also found that formal, structured training in ethics was less frequent in small firms than in large firms.

3.2.5 Clarity and Openness about Ethical Issues as Factors Supporting an Ethical Culture

Kaptein (2008a, 2008b, 2011) contends that clarity of ethical standards is an important component of an ethical culture. Several researchers have found an association between unethical behaviour in the workplace and an absence of clear ethical standards (Bird and Waters, 1989; Jackson, 2000; Tyler and Blader, 2005). Whereas vagueness and ambiguity about ethical standards portend ethical misconduct (Kaptein, 2011), clarity, on the other hand, has been shown to reduce the incidence and the likelihood of unethical behaviour (Hegarty and

Sims, 1979; Schnatterly, 2003). Kaptein lists three tests of clarity that ethical standards must meet: they must be concrete, comprehensive and understandable (2011; p. 847). Instead of keeping employees in a state of ignorance about the organization's ethical principles or leaving them to guess or to rely solely on their moral values and situational judgment, he recommends the creation of a culture of clarity where the difference between ethical and unethical behaviour is clearly articulated. Greater clarity, he argues might help employees avoid making ethical mistakes inadvertently or due to ignorance, and also act to elevate the importance of ethics, thereby, making it less likely that employees will go against the company's ethics code.

An organizational culture that encourages the articulation and discussion of moral issues is likely to facilitate ethical behaviour, suggests Kaptein (2011). There is some evidence to support the proposition that an atmosphere in which employees feel free to raise ethical questions, voice ethical concerns, and are able to engage in dialogue with their peers and superiors about ethical issues reduces unethical conduct (Trevino et al., 1999; Schnatterly, 2003). Kaptein (1998) found that one of the causes of ethical misconduct in some organizations was a culture that did not allow expression of ethical concerns or exchange of ideas on ethical issues. There was a strong unwillingness in these organizations to talk openly about ethical issues, and criticism was not encouraged or welcomed. Kaptein (2011; p. 850-851) proposes that cultures that are characterised by a 'persistent avoidance of moral talk', what Bird and Waters (1989; p. 73) describe as 'the moral muteness of managers', become havens of amorality. If discussion of ethical issues is actively stifled, or neglected through the absence of formal and informal mechanisms to promote open discussion and debate, moral concerns are degraded and lose their importance in the eyes of employees. The ethical standards of the organization cease to have any value or effect. They become impotent in influencing the conduct of employees. In contrast, opportunities to discuss ethical dilemmas openly, collectively, in a non-threatening atmosphere strengthen the capacities of individual employees and the organization to self-regulate and self-correct before it is too late (Kaptein, 2011).

Trevino et al. (1999) found that organizations in which employees were supported and encouraged to openly talk about and discuss ethical issues were organizations where employees were more likely to behave ethically. In contrast, in organizations where discussion of ethical issues was disapproved of and discouraged, misconduct was more frequent (Bird, 1996).

3.2.6 Socialization into Ethical Behaviour through Training

Trevino et al. (2006) argue that socialization processes in organizations are often responsible for the subsequent ethical or unethical behaviour of individual employees. In some organizations, right from induction, new hires are socialized into a different world view that has its own moral rules, into an alternate reality. New recruits are led gradually to so thoroughly accept and internalise the moral values of the organization that they no longer see the contradictions and discrepancies within the ideology that they have been taught to believe in. This is particularly likely in organizations that have very tightly knit cultures, which Collins and Porras (1994) describes as being almost cult-like in their strength, intensity and isolation from the wider world. Within this 'moral microcosm' (Trevino et al., 2006; p. 968), this 'social cocoon' (Anand et al., 2004; p. 46), employees are taken step by step through small ethical compromises (that begin to change their moral beliefs), through repetition of ethical violations on a progressively larger scale (which reinforce and cement the new moral attitudes), till the very distinction between right and wrong becomes non-existent or ceases to matter. Described by Ashforth and Anand (2003; p. 1) as the 'normalization of corruption', it is a process of indoctrination which is often required for employees to succeed and to be promoted to higher levels of responsibility. Ultimately, employees reach a stage of amorality rather than immorality, where they identify so completely with the organization's interests that any other perspective or concern simply becomes invisible to them (Trevino et al., 2006).

Hoffman et al. (2001) emphasizes the importance of making all the staff in the organization aware of ethical standards and breaches of ethical conduct. There is wide-ranging support for formal ethics training programmes, especially, for new hires, to increase their ability to make ethical decisions (Preston, 1996; Ferrell et al., 2010). A high level of ethical compliance requires socialization into an ethical mindset when an individual enters an organization as well as continuous reinforcement through ongoing training and development (Segon and Booth, 2013). This approach draws upon work on organizational design on crafting an organizational identity consistent with mission, values and behavioural expectations (Schein, 1985) and, if

successful, can help create 'a strong cohesive cultural identity' rooted in values and ethics (Segon and Booth, 2013; p. 110-111).

White and Lam (2000) recommend the development of an ethics training programme with the active participation of employees. They suggest that specific ethics training programmes be developed for different job roles. In creating a training programme for a particular role, employees in that role should be consulted about the practical, real-life, difficult ethical challenges that they confront in their work. Critical incidents and issues for which some employees in that job category have been disciplined in the past can also be a fruitful source for unearthing the ethical issues salient to that specific job role. Suggestive solutions to these contested and disputatious ethical problems and effective strategies for resolving similar ethically complex questions should, then, be discussed and agreed. In this process, input should be sought from all stakeholders: employees, managers, ethics and legal compliance officers, etc. Case studies based on these discussions should form the basis for an ethics training programme which should be disseminated across the organization, and all other employees in a similar job role should receive this training (White and Lam, 2000; p. 41).

Related to the earlier idea of orientation is that of specific needs-directed training to develop the ethical decision-making capabilities of staff. There is agreement among organizational theorists that the moral reasoning skills of most untutored employees are under-developed and could benefit from targeted training (Preston, 1996; Hoffman et al., 2001; Ferrell et al., 2010; Trevino and Nelson, 1995). While the need may be greatest for new employees, even existing employees can benefit from ongoing training in ethics. Approaches to helping develop the ethical decision-making skills of employees include education in theories of ethics and working through real-life scenarios, case studies, etc. (Ritchie, 1996).

Segon and Booth (2013) provide a concrete illustration of this kind of ethical training. In the Australian hospital described in their study, the senior executive team had received some training on using values to inform day-to-day behaviour and in modelling the values for other staff. However, below the senior executive team, no one else had received similar training. Segon and Booth raise several matters of concern in relation to the training. Firstly, though

some of the senior management had received ethical training, and the organization was making an effort to provide more ongoing training in this area, clinical staff had received insufficient training in ethical decision-making and practice. A further cause of concern, according to the researchers, was that there seemed to be a lack of a coherent strategy and a consistent, integrated approach. The approach to training in ethical decision-making and practice seemed rather *ad hoc* and did not meet the requirements of some stakeholders of the organization, thus, reflecting a need for better planning and coordination. The training that existed was inadequate and did not give staff the full range of ethical decision-making skills required by their roles. There was no systematic evaluation to ensure that the training had been successful in enabling staff to reach the desired standards of ethical knowledge and practice (Segon and Booth, 2013).

3.2.7 Other Ethical Support Structures

James (2000; p. 45) suggests that three aspects of organizational structure are highly relevant for ethical behaviour:

1. The reward system (including financial and non-financial rewards)

2. The performance evaluation and monitoring system

3. Decision-making rights and responsibilities (degree of staff empowerment)

These three structural components have been acknowledged to be key determinants of employee behaviour (Jansen, 1985; Jensen, 1983; Brickley et al., 1994). As James (p. 45) notes, these three components, though, distinct, are also connected to and influence each other. They need to be aligned so that they all support ethical behaviour. Any misalignments between them may lead to employees facing ethical tensions and conflicts (James, 2000). An example suggested by James is that of a situation where the organization's system of remuneration encourages ethical behaviour. However, if performance monitoring is inadequate and does not detect unethical behaviour, or if those who know the most about the ethical issues involved do not have the power to make ethical decisions, especially, when faced with temptations to behave unethically, then, a situation favourable to unethical behaviour is created and the

tendency of the remuneration system to promote ethical behaviour is partially negated (James, 2000).

The use of *ethics audits* as an organizational mechanism to drive progress in ethically responsible behaviour is another recommendation of White and Lam (2000). In proposing the use of ethics audits, they draw upon the work of de George (1995) who suggested the idea of *social and moral audits* as a method for organizations to assess and communicate to their various stakeholders their stance on social issues, and the impact of their policies on society (p. 13). An ethics audit, as proposed by White and Lam (2000), would be a 'proactive and continuous reassessment' (p. 38) of the organization's ethics policies to ensure their continuing relevance, and would also include a comprehensive periodic review of organizational practices to ensure that they were ethically sound. The authors' emphasis on scrutinizing organizational practices from an ethical perspective is a point worth noting, for, as they recognize, it is out of conflicting organizational imperatives that ethical tensions often emerge. The purpose of a periodic re-assessment would, therefore, be to identify organizational sources of ethical conflict and to remove these barriers to ethical behaviour and ensure that all organizational systems are fully aligned and harmonised with the organization's ethical values (White and Lam, 2000; p. 41).

Employees' commitment to behave ethically is identified by Kaptein (2008a) as another significant influence on the likelihood of ethical behaviour. Employees' commitment to behave ethically is a function of their commitment to the organization (Kaptein, 2011). Factors that affect employees' commitment to the organization include the trust they have in the organization, their perception of the fairness, respect and dignity with which they are treated, etc. Social Bond Theory suggests that one of the causes of unethical behaviour is a low degree of attachment and commitment to the community (Hirschi, 1969). Several studies have reported that a social environment characterised by distrust, low motivation and discontent and consequent weak ties to the community is conducive to deviance and disregard of the ethical norms of the society (Deutsch and Robinson, 2008; Greenberg, 1997; Skarlicki et al., 1999). Extended to organizations, this theory suggests that low commitment to the organization is likely to translate into low regard for the ethical standards of the organization and a higher risk of ethical misconduct (Kaptein, 1998). So, if employees are treated unfairly by the

organization, their commitment to the organization is likely to be reduced, and this may spill over and result in a lower concern to abide by its ethical standards. For a society, fostering a greater sense of attachment and commitment to the community may reduce the likelihood of ethical violations. For an organization, this means that creating a greater sense of identification with and commitment to the company is likely to promote greater adherence to its ethical codes and lower the chances of unethical behaviour (Tyler and Blader, 2005).

Several organizational theorists (Vidaver-Cohen, 1998; p. 1218; Boisjoly et al., 1989; Kanter, 1983; Trevino, 1990, Vandivier, 1972) have suggested that tightly compartmentalized task structures may tend towards reduced inter-dependence and erosion of accountability, thereby, creating a climate in which unethical conduct becomes more likely.

The preceding section outlined the most widely used approaches to building ethical organizations. The next section focuses on the role of leadership in creating ethical organizational cultures. This section begins by analysing how leaders influence culture and why their influence is so powerful. It, then, explores the various tools and levers used by leaders to give direction to the ethical culture of the organization (such as communication and values).

3.3. Leadership and Ethical Culture

In this section, the role of leaders in influencing their organization's cultures is elaborated upon. Examples are given of the different ways in which leaders influence their organization's cultures.

3.3.1 Leadership and Organizational Culture: A Neglected Area of Research

Trice and Beyer (1991) assert that organizational research on leadership has neglected to examine its impact on organizational culture. They claim that while there is a recognition and

a general acceptance of the importance of leadership in shaping organizational culture, the effect of leadership on culture has received 'scattered attention' (Trice and Beyer, 1991; p. 149) by theorists, and that the relationship between the two constructs has not been systematically explored (p. 149). Trice and Beyer give leadership a crucial role in the creation of cultures. They contend that a culture cannot emerge without leaders who communicate the ideas that make up the culture widely and repeatedly so that others come to share those same ideas. Leaders, they claim, impart to their followers the emotionally charged ideas which are the intellectual content of the culture. The articulation of a *vision* is another way of describing this leadership function.

The actions or behaviours of leaders, assert Trice and Beyer (1991), have dual results: actions both do *and* say certain things. What actions or behaviours *do* is described by Trice and Beyer as the 'instrumental' side of the action, and what actions or behaviours *say* as the 'expressive' side of the action (p. 150). Leaders influence both the instrumental and the expressive sides of the actions of the members of the organization. Leaders influence both how the work of the organization gets done, and they influence the meanings and interpretations that members of the organization give to, and reveal through, their actions. Trice and Beyer describe the former role as 'instrumental leadership' and the latter role as 'cultural leadership' (Trice and Beyer, 1991; p. 150).

Drawing on Schein's (1985) conceptualization of culture, Sims and Brinkmann (2003) assert that leadership may be the most decisive influence on an organization's culture (p. 247). Probably nothing is more important to an ethical corporate atmosphere than the moral tone and example set by an organization's top leadership (Sims and Brinkmann, 2002; p. 327). 'Just as the destiny of individuals is determined by personal character, the destiny of an organization is determined by the character of its leadership (Josephson, 1999; p. 13)'. Falkenberg and Herremans (1995) and Posner and Schmidt (1984, 1985) suggest that the conduct of leaders is the most significant influence on the behaviour of individual employees.

That leaders exercise a strong influence on and play a salient role in developing an ethical culture in organizations is not a particularly original idea (Paine, 1997). As far back as 1938,

Barnard (1938) stated that the creation of the morals of the organization is one of the primary and most challenging duties of leaders. This task, as he described, involved, firstly, articulating the ethical principles appropriate to the organization and that it committed itself to upholding, and, secondly, putting in place organizational arrangements which enabled employees to behave in a manner consistent with those ethical principles.

One chief executive of a large multinational firm described the crucial role that leaders play in creating an ethical culture by saying that the title *CEO* also stands for Chief Ethics Officer (Trevino and Nelson, 1995). In other words, the head of the organization has to be the highest exemplar of ethical behaviour. Their ethical conduct matters more than that of any other employee. Their behaviour must reflect the highest ethical principles and the strongest ethical commitment.

3.3.2 How Leaders Shape Organizational Cultures

The expression of a clear and strong commitment by the senior leadership to ethical norms of behaviour is an important step towards the development of an ethics-oriented organizational culture (Laczniak, 1983). Subordinates observe their leaders' behaviour closely and take cues on how to behave themselves (James, 2000).

Both Hoffman et al. (2001) and Segon (2007) agree that ethical behaviour starts at the top, that if leaders want their employees to behave ethically, they need to send a clear signal by themselves showing an explicit long-term commitment to ethics. A high standard of ethical behaviour requires that senior leadership take ownership of the ethics function and that clear lines of responsibility and accountability for the ethical function are established (Segon and Booth, 2013). To be effective, an ethics programme requires initiative and consistency from the highest levels of leadership (Segon and Booth, 2013).

Leaders of organizations set the standards for ethical behaviour, and the moral values that they demonstrate guide the ethical behaviour of their employees. Grojean et al. (2004) assert that leaders have an 'enormous impact' on the ethical cultures of their organizations. Their own actions as well as the actions of others that they encourage and reward create expectations and norms of appropriate and acceptable behaviour which become ingrained in an organization's culture over time and 'establish the ethical tone of an organization' (Grojean et al., 2004; p. 224). In the views of Dickson et al. (2001), the actions of leaders communicate and demonstrate to employees the true importance with which ethical behaviour is regarded in the organization. Leaders at Enron created a culture that was 'morally flexible', thus, contributing to the degradation of the ethical fibre of the company and resulting in the unethical behaviours of the employees that followed (Sims and Brinkmann, 2003; p. 247).

Collins and Porras (1994) cite an example from the history of the Hewlett-Packard Company to underscore the role of leadership in creating an ethical organizational culture: 'Bill Hewlett and David Packard constantly emphasized the importance of never compromising the long-term principles and health of HP for the sake of quick, expedient profits. For example, David Packard pointed out in 1976 that anytime he discovered an employee had violated HP's ethical principles in order to increase short-term divisional profits, the individual involved was fired - no exceptions, no matter what the circumstance, no matter what the impact on the immediate bottom line. HP's long-term reputation, in Packard's view, had to be protected under all circumstances' (p. 191).

3.3.3 Leaders as Role Models of Ethical Behaviour

Social Learning Theory (Bandura, 1986) posits that people learn by observing the behaviour of others and the consequences of behaviour. If a new mode of behaving results in desirable consequences, it is added to an individual's repertoire of potential behaviours and is enacted in the appropriate situation. This method of learning and acquiring new patterns of behaviour is known as the *modelling of behaviour* (Wood and Bandura, 1989). Leaders are the most important role models for employees; the conduct of leaders is a strong influence on the behaviour of individual employees. Leaders lead through personal example (Grojean et al.,

2004). Their behaviours set the example for employees, and are emulated by others (Andrews, 1989; Waters and Bird, 1987a, 1987b; Posner and Schmidt, 1984, 1985; Bandura, 1986). Grojean et al. (2004) suggest that leaders play an important role in setting the standard of appropriate conduct for the organization: they define what is considered desirable behaviour what is not. The actions of leaders communicate powerfully the values, expectations and assumptions of the culture (Grojean et al., 2004). Subordinates derive their perceptions of what is necessary for career advancement from the behaviour of leaders and align their actions accordingly (Grojean et al., 2004). In other words, subordinates *model* their behaviour on the pattern or template set by the leaders. Leaders inspire by modelling behaviour which is adopted by others, not in the hope of material gain, but because it is perceived as the correct thing to do (Grojean et al., 2004). The behaviour of leaders plays a key role in the establishment and maintenance of the *norms* of behaviour in the organization (Schein, 1983).

It has been stated before that leaders direct employee behaviour by what they pay attention to and by modelling the desirable mode of conduct for achieving organizational success (Sims, 2000; Sims and Brinkmann, 2003). Therefore, if short term results are all that leaders care about, employees will do the same (Stern, 1992; Trevino and Nelson, 1995).

The vital role played by role models, both the employee's immediate supervisor or manager and the senior leadership of the organization, is highlighted by Kaptein (2008a) as an important formative influence on the ethical character and conduct of employees. Due to their status, higher ranking in the organizational hierarchy, and the power and prestige associated with their position, the employee's immediate manager and the organization's top management are perceived by many employees as role models (Brown et al., 2005; Schein, 1985). That employees follow the example of ethical or unethical behaviour set by their role models is demonstrated by several studies (Kaptein, 1998; Brown et al., 2005; Hegarty and Sims, 1979; and Schminke et al., 2005).

If the ethical behaviour of role models is inconsistent with the organization's ethics policy, or if their words and deeds contradict each other, then their subordinates' desire to act ethically is likely to be undermined. In contrast, if the behaviour of role models demonstrates a consistent

pattern of upholding the ethical principles of the organization, employees are likely to be reinforced in their motivation to behave ethically. Dineen et al. (2006; p. 623) found that 'behavioral integrity', i.e., a pattern of alignment between the words and actions of role models increases the probability of ethical compliance and makes unethical behaviour less likely. Mayer et al. (2009) suggests that while the influence of the immediate superior is stronger due to the closer relationship, more frequent contact, and more direct power over the subordinate, the behaviours demonstrated by senior leadership, too, can have a strong impact on the behaviour of employees. Though the executive class may be more distant, the cachet, significance, and reach associated with the senior leadership role makes their actions both conspicuous and highly influential among subordinates (Trevino et al., 2003).

The leader's conduct when organizational goals (say, profitability) and ethics conflict communicates more eloquently than anything they may say. Trevino and Brown (2004) cite the example of Arthur Andersen, the founder of the accounting firm named after him. His firm stance on professional integrity and ethical conduct was legendary throughout the company. One story of his early years, in particular, was told over and over again to reinforce the message that ethics mattered in this company. Arthur Andersen was quite young, 28 years of age at that time. He was auditing the accounts of a railway company. When he discovered that the company was in financial trouble, the client's management attempted to doctor his audit report. They threatened him with dire consequences if he didn't make his report more favourable to the company. In response, he is reported to have replied: 'There is not enough money in the city of Chicago to induce me to change the report' (Trevino and Brown, 2004; p. 74). He lost the client but the railway company had to declare bankruptcy soon and his firm gained trustworthiness and credibility. This story circulated within the company for years afterwards and was recounted to new hires as an emblem of its integrity and evidence of its 'Think straight, talk straight' philosophy. The lesson to learn from Arthur Andersen, suggest the authors, is that leaders need to take the lead on ethics as in other important areas for the organization such as quality, costs, productivity, etc. Moreover, leaders need to be vocal about ethics. Even formal ethics programmes, they warn, can be rendered ineffective if they do not have the leader's whole-hearted backing (Trevino and Brown, 2004).

Brown et al. (2005) found that employees who perceived their leaders to be ethical, fair and caring were more likely to bring ethical or other organizational problems to the knowledge of management. Reporting problems, or bad news, or news of something that has gone wrong may not be required of employees; however, in certain situations, it might be a proactive step that might be helpful to the management. Employees are more likely to take this risk if they trust that their leaders will give them a fair hearing and do the right thing (Brown et al., 2005).

3.3.4 Creation of Organizational Systems to Promote Ethical Culture

In small organizations, leaders are able to monitor and regulate the behaviour of employees personally and through word of mouth (Baker, 1997; Grojean et al., 2004). In larger organizations, this regulation is achieved by the formalization and institutionalization of rules, policies and procedures, which leaders have an important hand in designing (Quinn and Cameron, 1983). Another instrument which leaders use to influence the culture of an organization is mechanisms of socialization such as training programmes. Leaders impact the culture of an organization by influencing an important aspect of organization design: the reward systems. Systems for the evaluation of performance and the distribution of rewards are potent influences on the behaviour of individuals. These rewards could be financial (such as promotions, more resources / a bigger budget, higher salaries, bonuses, perks) or non-financial (more autonomy, more responsibility, recognition, opportunities for more diverse work or to lead interesting and challenging projects, status, trust, respect / esteem). By shaping financial and non-financial incentives, leaders exercise an important control on the culture of the organization (Grojean et al., 2004). Hoffman et al. (2001) and Segon (2007) agree that it is the responsibility of senior leadership to ensure that the ethics function is properly resourced and managed.

Trevino and Brown (2004) clarify that there are two roles that an effective leader attempting to create an ethical organizational culture must enact: the role of a 'moral person', and the role of a 'moral manager' (p. 75). To create an ethical culture, the leader has to, first of all, demonstrate impeccable ethical conduct. They must demonstrate the highest moral character and integrity in their person. Their decisions have to be based on the highest ethical values and moral

principles. However, Trevino and Brown add a crucial insight that it is not enough for the leader to be a moral person themselves. The authors say that 'leaders must be more than individuals of high character. They must "lead" others to behave ethically... But being perceived as a "moral person" is not enough. Being a "moral person" tells followers what the leader will do. It doesn't tell them what the leader expects *them* to do.' (p. 75).

The second role of the ethical leader is that of a *moral manager*, one who defines the ethical values and standards that he and the rest of the organization must adhere to, and who establishes concrete mechanisms and systems, including appropriate reward and disciplinary mechanisms, to steer employees towards the desired behaviour. As a moral manager, the leader communicates the message of ethics loudly and clearly so that employees are left in no doubt as to the ethical expectations of them, and holds them accountable to ensure that these expectations are met.

Being a moral individual, argue Trevino and Brown (2004), helps leaders realise only the 'ethical' part of 'ethical leadership' (p. 79). The equally important 'leadership' part of 'ethical leadership' is realised when they a) make ethical values 'visible', for instance, by articulating both the desired ends, say, bottom line financial results as well as the means, i.e., the acceptable and unacceptable ways of achieving the end goals; b) by being transparent and open about the challenges involved in balancing competing and conflicting goals and by making the deliberations involved in arriving at the decisions public (with an appropriate degree of disclosure); c) by declaring publicly the responsibilities of the organization to its various stakeholders – customers, employees, shareholders, society – and how the organization is meeting, or not meeting, its duties towards them, and the likely impact of important decisions on the various stakeholders; d) and by designing the compensation, reward and promotion systems so that they encourage ethical employees and discourage the violators (2004, p. 79-80). Arthur Andersen, argue Trevino and Brown (2004), was such a leader. He was a highly ethical individual himself but, vitally, he also *led* his organization to be ethical. He upheld high ethical standards himself, and his staff knew that he expected similar standards from them.

3.3.5 Ethical Leadership through Communication

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In situations that involve ambiguity and confusion, leaders clarify issues, suggest ways of tackling them, and set boundaries for action, thus, giving direction to the organization's culture (Grojean et al., 2004). Leaders shape the behaviours of their subordinates by providing feedback, coaching, and mentoring (Grojean et al., 2004).

Trevino and Brown (2004) suggest that communication of ethical standards is one of the primary tasks of the leadership. Just as it is the role of leaders to stimulate improvements in the organization in the areas of quality, efficiency, etc., it is a crucial part of the leadership role to lead on ethics. Employees expect the impetus for ethical behaviour to come from the top, and if leaders remain silent on the importance of being ethical, they fail in a crucial element of leadership. The authors argue that silence on ethical issues by organizational leaders has an adverse effect on the ethical behaviour of their subordinates. While leaders themselves may be ethical, their silence, argue the authors, has important ramifications (Trevino and Brown, 2004).

Firstly, suggest Trevino and Brown (2004), the silence of leaders on ethical issues might be perceived by their staff as an indication of neutrality, ambivalence, or worse. Silence, suggest the authors, is usually the mark of leaders who do not take a strong position, either for or against, ethics. The lack of a strong and clear voice on ethical questions from the leadership might be construed by some of their followers as indifference and unconcern. If employees are uncertain about their leader's position on the importance of ethics, their predicament when faced with an ethical dilemma increases. Subordinates may question or doubt their leader's commitment to ethics and orient their behaviour accordingly. Silence, too, sends a message, argue Trevino and Brown (2004). The rank and file may conclude that the message being communicated from the top is that what their leader cares about (and, therefore, what the organization expects of them) is solely bottom line results and the achievement of organizational goals, without regard for the ethicality of the means by which they are achieved.

Given the constant stream of messages emanating from the top on various pressing organizational issues, a second consequence of the leader's silence on ethical issues is that ethics can easily get sidelined and reduced to a tokenistic gesture such as a poster, a website, a piece of paper and a tick box exercise (Trevino and Brown, 2004). It is easy for the message of ethical behaviour to get drowned out amidst the background din of communiqués on the organization's financial performance, the latest moves of competitors, initiatives for cost reduction and improvement of quality standards, etc. unless there is a conscious, concerted and constant effort to raise ethics above the noise and make it heard. In fact, Trevino and Brown (2004) go so far as to recommend that 'in order to compete with this constant drumbeat about the short-term bottom line, the messages about ethical conduct must be just as strong or stronger and as frequent' (p. 78). The authors suggest that leaders have to do more than merely repeat the theme of the value and necessity of ethical conduct. It is incumbent on the leader to ensure that all employees are adequately prepared for the ethical issues common to their industry and role and that they know what to do when tensions arise between organizational goals and ethics. Moreover, it is the leader's responsibility to drive home the message that ethics is essential to the organization's performance and not something trivial and peripheral, and that ethical behaviour is an indispensable requirement for sustainable, long term success (Trevino and Brown, 2004).

It is a mistake and potentially dangerous (and self-deluding), in the view of Trevino and Brown (2004), to neglect the development of the ethical culture, to put blind faith in the good judgment of their subordinates, and to believe that ethics will manage itself. Leaving the ethical culture to manage itself, they argue, is only likely to send mixed signals to employees and confuse them further. In the absence of clear and explicit messages from the very top that ethics matters, employees will not know which direction to take when faced with the inevitable and frequent tensions between organizational goals and ethics. They will construe the leader's silence as an indication that when organizational goals and ethics conflict, priority should be given to the former. Even though the leader may be a highly ethical person themselves, their passivity in communicating the importance of ethics to their subordinates is likely to be seen as a declaration of a lack of interest in safeguarding ethics and, possibly, a *de facto* silent approval of less than ethical activities in the organization (Trevino and Brown, 2004).

3.3.6 How Leaders Influence Culture by Shaping the Value System of the Organization

Schein (1992) suggests that founders of organizations or leaders in the early stages of development of organizations play a crucial role in shaping its culture. The values of the founders and early leaders, argues Schein, are the foundations upon which the social character of the organization is based. Their values permeate the social character or environment of the organization, which acts to encourage or discourage ethical behaviour. Their values colour the organization's culture as they are woven into the systems for allocation of rewards, resources and organizational status, and into organization structure, mission, rites and rituals (Schein, 1992).

Grojean et al. (2004; p. 225) define *organizational values* as 'relatively stable beliefs that certain modes of behaviour (instrumental values) or end-states (terminal values) are desirable (also, see Meglino and Ravlin, 1998; Rokeach, 1973). Organizational values guide the behavioural choices made by the members of an organization as people gravitate towards the ends and the means that are valued (Grojean et al., 2004; Locke, 1991; McClelland, 1985; Rokeach, 1973).

The values held by leaders, having the weight of their authority, power, and prestige behind them, are extremely influential (Sims and Brinkmann, 2002). The values exemplified by leaders activate or elicit similar values in their followers. The values of leaders also cause changes in the values of individuals as the latter seek to achieve 'value congruence' or harmony between their own values and those of their leaders as they see it being necessary to advance in the organization. Leaders also influence the culture by attracting and retaining individuals who share their values and who are likely to 'fit' well with them (Grojean et al., 2004).

A strong ethical leader, who created an ethical organizational culture by emphasizing values, was James Burke (Trevino and Brown, 2004). Burke was the CEO of the American pharmaceutical and consumer products company Johnson and Johnson (henceforth, J&J) during the Tylenol crisis in the 1980s. Tylenol was a best-selling pain reliever and one of J&J's most profitable products. In 1982, seven people in Chicago were found to have died after taking

Tylenol. Subsequent investigations discovered that the Tylenol that they had consumed had been tampered with and laced with a deadly dose of cyanide (The New York Times, March 23, 2002).

Burke's handling of the Tylenol crisis is cited as a classic case study of exemplary ethical leadership (Collins, 1994). He quickly initiated a national recall of all the Tylenol stock at a cost of $ 100 million to the company even though the deaths were limited to the Chicago area. The company launched a massive communications effort to alert customers to the risks of Tylenol and advised them to refrain from using any kind of Tylenol product. According to Collins (1994), the company's response to the crisis was heavily influenced by its Credo, its official statement of its core ethical values. J&J's Credo states: 'We believe our first responsibility is to the doctors, nurses and patients, to mothers and fathers and all others who use our products and services'; the company declares that 'The values that guide our decision making are spelled out in Our Credo. Put simply, Our Credo challenges us to put the needs and well-being of the people we serve *first* (Johnson and Johnson 'Our Credo Values', 2016). By acting in accordance with the Credo and placing the public's safety ahead of profits, J&J was able to regain the public's trust.

The Washington Post praised the company's ethical approach to the crisis: 'From the day the deaths were linked to the poisoned Tylenol until the recall on Thursday, Johnson & Johnson has succeeded in portraying itself to the public *as a company willing to do what's right regardless of cost*...Serving the public interest has simultaneously saved the company's reputation. That lesson in public responsibility - and public relations - will survive at Johnson & Johnson regardless of what happens to Tylenol' (The Washington Post, October 11, 1982). TIME magazine wrote: 'Burke emphasized the value of the J&J Credo, dating back to the company's founding in 1887, which stated that the company is responsible first to its customers, then to its employees, the community and the stockholders, in that order'; it quoted him as saying, 'The Credo is all about the consumer. [When those seven deaths occurred] The Credo made it very clear at that point exactly what we were all about. It gave me the ammunition I needed to persuade shareholders and others to spend the $100 million on the recall. The Credo helped sell it' (TIME, October 5, 2012).

What is particularly remarkable about Burke's leadership is that he had started building J&J's ethical culture well before the Tylenol crisis struck (Trevino and Brown, 2004). Collins (1994) argues that J&J was able to weather the crisis and come out triumphant because it was so strongly rooted in its ethical values. J&J's strong grounding in its values made the correct response more or less self-evident, argues Collins. The process of re-focusing the company on the ethical philosophy and values on which it had been founded had started well before the crisis struck. As a result, J&J was better prepared for a crisis of this nature than other less values-driven companies might have been (Collins, 1994). Before Burke took over as the CEO, J&J had been moving away from the values enshrined in the Credo. Burke began the process of bringing J&J back to the Credo. He challenged his senior executives to either commit to living the Credo fully or tearing the Credo off the walls (Trevino and Brown, 2004): 'People like my predecessors believed in the Credo with a passion, but the operating managers [in 1979] were not universally committed to it.... So I called a meeting of some 20 key executives and challenged them. I said, "Here's the Credo. If we're not going to live by it, let's tear it off the wall.... We either ought to commit to it or get rid of it." ... By the end of the session, the managers had gained a great deal of understanding about and enthusiasm for the beliefs in the Credo. Subsequently, [we] met with small groups of J&J managers all over the world to challenge the Credo' (Collins, 1994; p. 72).

Burke revitalised the Credo, making it a living, vital force that shaped the company, a 'moral compass' that guided it in ordinary times and in crises (Johnson and Johnson 'Our Credo Values', 2016). According to Collins (1994), Burke spent nearly 40% of his time communicating the Credo to his employees. The Credo was translated into operational practice and integrated into all the key organizational processes: strategic business planning and decision-making, remuneration systems, organizational structures, etc. (Collins, 1994). Under Burke's ethical leadership, the Credo became a real support to all the employees of J&J in acting ethically: 'All of our management is geared to profit on a day-today basis. That's part of the business of being in business. But too often, in this and other businesses, people are inclined to think, "We'd better do this because if we don't, it's going to show up on the figures over the short-term." This document [the Credo] allows them to say, "Wait a minute. I don't have to do that." The management has told me that they're...interested in me operating under

this set of principles, so I won't' (Collins, 1994; p. 80). To identify double standards and discrepancies between the Credo and actual operating practice, Burke initiated an annual Credo survey which asked employees how well their actual behaviour conformed to each of the principles in the Credo (Trevino and Brown, 2004). Burke demonstrated exemplary ethical leadership by being both highly ethical in his own conduct and bringing the organization into alignment with its ethical values and guiding principles through tangible, concrete and potent mechanisms.

3.4. Organizational Values and Ethical Culture

Ethics and organizational values are closely related. A clear articulation of the organization's values, emphasize Segon and Booth (2013), is important because it defines the 'moral identity' of the organization for those inside and outside the organization (p. 94). The statement of values also sets out clear, enduring standards of ethical and unethical conduct for employees (Segon and Booth, 2013).

Segon and Booth (2013) suggest that to create a value-driven ethical culture, it may be useful to clarify organizational values through statements that explicate and concretise the values. By turning abstract, general values into specific behaviours that all the staff in the organization are expected to emulate, these clarifying statements aid in the interpretation and application of organizational values. Segon and Booth provide examples of value-clarifying statements from an Australian hospital:

Value: Compassion

Our drive to care is not just a professional duty to provide excellent quality care but is born of a heartfelt compassion for those in need...We put people first as we look to provide extra support and care, beyond our professional duties.

Value: Integrity

We...remain faithful to the bold healing mission and legacy of our founder. We remain true to our beliefs at all times – our mission and values are non-negotiable.

Value: Respect

We believe that every person is worthy of the utmost respect and the best possible healthcare. We know that our resources are entrusted to us to use for the benefit of others. We uphold the worth and dignity of all people, regardless of gender, race, age, ability and social position, and treat them with courtesy, respect, equality and justice.

Source: (Adapted from: Segon and Booth, 2013; p. 105 - 106)

Figure 3.2 Values of the Hospital (Segon and Booth, 2013; p. 105 - 106)

Communicating organizational values and ensuring that all staff are fully aware of the organization's code of ethics and the expected mode of behaviour are important steps in creating an ethical climate (Segon and Booth, 2013; Ritchie, 1996; Hoffman et al., 2001; Ferrell et al., 2010). Among the strategies used by this hospital to ensure that all staff were aware of its ethical values was the distribution of the booklet containing the code of conduct to all staff (Segon and Booth, 2013). Subsequently, senior management went around the organization visiting wards and testing staff's awareness of the values and ethical codes of conduct. This had a twofold benefit.

Firstly, senior leaders discovered that the dissemination of information was incomplete and that many staff were not aware of the values and codes. When asked, senior managers expressed uncertainty about whether all staff had received the booklet. White and Montgomery (1980) report a similar finding that managers often do not make all staff aware of the organization's ethics codes. Some staff had received the booklet but had not read the content; fewer still were using the values and ethical codes regularly in their practice. The second benefit of this exercise was that the questioning by senior management made the values and ethics codes very visible and reinforced their importance to staff up and down the ranks.

At the hospital studied by Segon and Booth (2013), organizational values were included in the selection process. Thus, potential employees were made aware of the values at a very early stage when their impressions of the organization were still unformed and their attitudes and behaviours had not hardened. All new employees went through an orientation programme during induction that was intended to familiarize them with the values and ethical behaviours that senior leadership expected all staff to demonstrate in daily practice.

However, Segon and Booth sound a note of caution about this exercise, suggesting that the orientation sessions may have provided employees with information, but whether they resulted in the values and ethics being translated into actual daily practice was uncertain. There remained a possibility that the point of the exercise, that these values and ethics were intended to inform the job roles of the new employees in a comprehensive, deep and meaningful way, that values and ethics were not mere window dressing but were a very important part of their jobs, and were meant to be incorporated into everyday practice on a regular basis, did not register with the audience. Thus, as the researchers cautioned, to achieve its purpose and to be effective as a method of training rather than mere information, ways have to be found to ensure that the message goes beyond the level of cognition and that efforts are made to embed the values and ethics in a consistent and sustained way into the whole of practice.

Paine (1994) advocates an 'integrity strategy' to achieve this (p 111). At the heart of the *integrity strategy* lie the organization's values and standards. These values and standards must be *integrated* into all the key organizational structures. The critical activities of the organization

(such as planning and goal-setting, search for opportunities, measurement of performance, criteria for promotion and advancement, resource allocation, and decision-making processes) must be designed so as to be congruent with and to reinforce these values and standards (Paine, 1994; p. 112). Paine emphasizes that without the enshrinement of the organization's deepest values and standards in the heart of the organization and its vital systems, any ethics programme will remain a largely surface-level and shallow influence: 'A glossy code of conduct, a high-ranking ethics officer, a training programme, an annual ethics audit—these trappings of an ethics programme do not necessarily add up to a responsible, law-abiding organization whose *espoused values match its actions*. A formal ethics programme can serve as a catalyst and a support system, but organizational integrity depends on the *integration* of the company's *values* into its *driving* systems' [italics added] (Paine, p. 112).

Employees are more likely to adopt the ethical values of the organization in their practice if they are actively involved in creating them (Longstaff, 1997). Segon and Booth (2013) suggest that a participatory approach may be more effective in influencing behaviour than a top-down imposition (also, see Vidaver-Cohen, 1998).

3.4.1 The Creation of a Values-driven Ethical Culture at Levi Strauss & Company

Mitchell and O'Neal (1994) cite the exemplary determination of a private sector organization, Levi Strauss & Company, to live by its values. Robert Haas, the Chairman and Chief Executive Officer, led a drive to revive and re-vitalise the organization's values. Howard (1990) states: 'Many CEOs talk about values, but few have gone to the lengths Haas has to bring them to the very center of how he runs the business' (; p. 2). Haas acknowledged the role of organizations in inculcating undesirable behaviours: 'Organizations typically teach us bad habits—to cut corners, protect our own turf, be political' (Howard, 1990; p. 8).

3.4.2 The Business Rationale for a Values-Based Strategy

The company's values-based strategy, explained CEO Robert Haas, went beyond doing things merely because they felt good (Howard, 1990). Describing the values as the foundation for 'responsible commercial success', Haas argued that values were essential to competing in the new marketplace and offered a compelling business case for the importance with which values were held in Levi's: 'We are not doing this because it makes us feel good - although it does. We are not doing this because it is politically correct. We are doing this because we believe in the interconnection between liberating the talents of our people and business success' (Mitchell and O'Neal, 1994; p.1-2).

The command-and-control style of management, argued Haas, was passé (Howard, 1990). To succeed in the fast-paced fashion industry, with rapidly evolving consumer tastes, and increasing global competition, a new culture, a new mindset and a new style of management was called for. Responding to the increasing pace of change, transient consumer needs, and widening of consumer choice required a flexibility, agility, and nimbleness that the earlier hierarchical organizational structure and centralised decision-making style did not permit (Howard, 1990). The earlier style of management where decision-making power was concentrated in the hands of senior managers was no longer fit for purpose. The realities of the new marketplace demanded the devolution of decision-making power to those who were closest to customers, argued Haas. Organizational goals would have to be discussed and negotiated with the whole team instead of being set unilaterally by management and imposed on subordinates (Howard, 1990).

Haas claimed that the changed marketplace required a different kind of employee (Howard, 1990). The old culture of paternalism where employees depended on their superiors to make decisions and passively followed their superiors' instructions had to give way. Following orders and doing what you were told to do would not be good enough. Employees would have to cultivate a new set of attitudes and behaviours (Howard, 1990).

The key to success in the new economy lay in empowered employees who had much more information and authority to make decisions in the best interests of the company (Howard, 1990). The ones who succeeded in the new marketplace would be those who were willing to

accept responsibility for making decisions on their own and to be held accountable for their performance (Howard, 1990). They would behave like entrepreneurs and treat their part of the company like their own business. In large corporations such as Levi's, Haas asserted, managers would not always be around to give the right answers. So, responding to the needs of customers would challenge employees to exercise their judgment, initiative and creativity. The new economy placed a premium on communication, so, employees would have to establish clear and accurate channels of communication with partners and customers (Howard, 1990).

The new set of attitudes and behaviours, Haas argued, could not be ordered into existence (Howard, 1990). They could only come through leadership and values. Values were necessary and vital, he observed, because traditional ways of controlling staff were no longer effective. The new controls, he suggested, had to be conceptual. Employees would only be motivated to give their best to the organization if they believed in the ideas that the organization stood for. It was not enough, he suggested, to have a sound structure and strategy; the strategy would be ineffective or only partially effective, he claimed, if staff didn't believe in it (Howard, 1990). If empowered employees with greater freedoms and a wider scope of action were the way forward, values, he averred, were key to guiding their behaviour. The company's values defined a shared set of standards that employees could take recourse to and use as a compass in navigating the new business landscape. Levi's code of values, the Aspirations Statement, set forth the new behaviours and attitudes, the new culture, that the company believed to be essential to success in the new marketplace and that it aimed to inculcate in its employees (Howard, 1990).

Haas accepted that the new behaviours were risky and likely to induce anxiety among employees used to the old ways of working (Howard, 1990). The usefulness of a clear public statement of the company's desired values was that it gave employees a point of reference to support and defend the new styles of working. For instance, the company's value on empowerment and its emphasis on honest and direct communication was likely to lead to more frequent disagreements between employees, and that was alright. He agreed that choosing to disagree with or expressing criticism of one's colleagues or superiors was difficult (Howard, 1990). Having a code of values that the company unequivocally supported, and being able to defend their behaviour by referring to the organization's stated values and standards made it

safer for employees to voice their true opinions and gave them the confidence to take the risk of expressing disagreement or criticism (Howard, 1990).

Haas cited examples of how the company's renewed emphasis on its values had the potential to promote a more ethical culture (Howard, 1990). Employees could suggest to their boss that they refuse to use a supplier who was known to ill-treat workers as using such a supplier violated the company's ethical standards. If Levi's was slow in making payments to a supplier in order to conserve cash, they could point out to their managers that this supplier had been a trusted partner of the company for a long time, and that they were in difficult straits, and that it would be better for Levi's and in the long-term interest of the relationship to pay their dues on time (Howard, 1990).

Financial incentives were used by Levi's as a key lever to embed values in the organizational culture (Howard, 1990). A third of a manager's financial compensation (pay increases, bonuses, and other monetary rewards) was tied to how well they practiced 'aspirational behaviour' in managing their staff; in some departments, value-related behaviour was given even greater weight. In performance evaluations, *how* leaders managed their people was scrutinised as much as *what* they did. Promotion within the organization was contingent on the member of staff exhibiting aspirational behaviours and demonstrating improvement in this respect (Howard, 1990). Haas explained that linking money and advancement in the organization in a very direct way to the values played a crucial role in obtaining compliance with the company's values-based strategy: 'The point is, it's big enough to get people's attention. It's real. There's money attached to it. Giving people tough feedback and a low rating on aspirational management means improvement is necessary no matter how many pants they got out the door. Promotion is not in the future unless you improve.' (Howard, 1990; p. 18).

3.4.3 Value 1: Equality and Diversity

One of Levi's values was recognizing, respecting and promoting diversity (Howard, 1990). The Aspirations Statement articulated the ideal that the company strove to attain:

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'Diversity: Leadership that values a diverse work force (age, sex, ethnic group, etc.) at all levels of the organization, diversity in experience, and diversity in perspectives. We have committed to taking full advantage of the rich backgrounds and abilities of all our people and to promoting a greater diversity in positions of influence. Differing points of view will be sought; diversity will be valued and honesty rewarded, not suppressed' (Howard, 1990; p. 3).

Before CEO Haas's re-energising of the company values, many ethnic minority employees of the company felt disillusioned about the lip service paid to valuing diversity as they repeatedly watched highly qualified colleagues from ethnic minority communities get ignored for promotions in favour of candidates that top management 'were comfortable with' (Mitchell and O'Neal, 1994; p.1). While the company had a principle of offering equal opportunities for employment and advancement, and, indeed, performed better in this respect than many other American corporations, there still existed a lot of unconscious prejudice and discrimination against ethnic minority employees (Howard, 1990).

In 1985, a group of female and ethnic minority managers sought an interview with Haas and expressed their strong frustration over the company's hypocrisy about diversity and the discrimination that thwarted their progress in the company (Howard, 1990). Shortly after this interview, Haas initiated some major steps to make the valuing of diversity a reality and to remove some of the barriers for female and ethnic minority employees. A training session was organized for ten senior male white managers who were each paired with an ethnic minority employee who worked under them. These managers had been under the impression that the company was doing quite well in terms of recruiting and promoting people fairly and from all backgrounds. Their conversations with their more junior female and ethnic minority reports proved to be an eye-opener for them (Howard, 1990).

The acutely uncomfortable, sometimes painful, discussions that followed over the next two and a half days, revealed to the senior managers the extent of disappointment, pain, and

despondency that their reports felt about the discrimination that they faced (Howard, 1990). The numbers, it appeared, weren't telling the full story. It was accepted that much unconscious discrimination still existed in the company and that attitudes needed to be changed. These sessions were continued in subsequent years and helped many male white managers and female and ethnic minority employees to engage in dialogue to examine and uncover the pre-conceptions and cognitive biases that influenced their behaviour towards people from other genders and ethnicities (Howard, 1990).

As a result of these deliberations, the company adopted a policy of promoting full diversity throughout the organizational hierarchy (Howard, 1990). In 1987, diversity was added as a core value to the company's Aspirations Statement. The scope of diversity was widened beyond offering equal opportunities for employment and advancement to valuing a diversity of perspectives, pro-actively seeking different points of view, and ensuring that different opinions were heard and given fair consideration in the making of important organizational decisions (Howard, 1990).

Based on the recognition of the additional challenges that female and ethnic minority employees encountered, special career development courses were created to cater to the unique and specific needs of women, Africans, Hispanics, and Asians (Howard, 1990). Support networks were set up for each of the major ethnic minority groups to assist them in their career development. These support networks provide female and ethnic minority staff a direct link to senior management and allow them to express any concerns or raise any issues to the highest level of management. In 1989, the company instituted a three-day 'Valuing Diversity' training course. Initially meant for senior managers, this programme was gradually extended to all employees (Howard, 1990).

The company had always had values like 'workplace diversity' and ethical outsourcing but to many ethnic minority employees of the company and the people working in its factories in developing countries, it had felt like 'talk, talk, talk' (Mitchell and O'Neal, 1994; p. 1). However, this time the changes went beyond mere hollow rhetoric. Incentives such as pay raises were made contingent on promoting the ethical values that the organization aspired to.

A third of employees' performance evaluations was linked to 'aspirational' behaviour ('Aspirations' being the name of the company's formal code of ethics) (Mitchell and O'Neal, 1994; p. 2-3). *Aspirational* behaviour included ethical values such as diversity, inclusion, and empowerment. Those who did not take the ethical values seriously were at risk of losing their incentives. Interestingly, in a noteworthy recognition that organizational design was one of the contributory factors to an ethical culture, one of the desired leadership behaviours in the Aspirations Statement was management's 'willingness to acknowledge our own contributions to problems' (Howard, 1990; p. 3).

Between 1984 (when Haas became the CEO) and 1994 (when this article was published), the proportion of managers from ethnic minority communities had doubled to 36%; women's representation in management positions had also increased significantly from 32% to 54%; Levi's performance in both these areas well exceeded that of the average American corporation (Mitchell and O'Neal, 1994; p. 4). As an African American employee who had recently been promoted to lead the company's European division said, 'We started to improve at Levi's when we stopped talking about values like diversity and started behaving that way' (Mitchell and O'Neal, 1994; p. 1).

As part of its value of empowerment, the company aimed to enable all employees to air their views, and ensure that their views were listened to with serious and fair consideration. 'Honesty', 'openness' and 'respect' in communication were prioritised as key elements of the value of 'empowerment' (Mitchell and O'Neal, 1994; p. 3). That this value of empowerment was actually being enacted was suggested by the experience of a female financial planner who politely expressed her displeasure at her manager's behaviour towards her which she didn't like. She was pleasantly surprised when the superior accepted the criticism with good humour and changed their behaviour. She said afterwards, 'I found that Aspirations isn't about New Age feel-good. It is about being open and direct' (Mitchell and O'Neal, 1994; p. 3). The company's emphasis on honest, open, two-way communication was reinforced by its 360 degree performance appraisal process wherein every employee was evaluated not just by their superiors but also their peers and subordinates (Mitchell and O'Neal, 1994).

Another expression of the company's commitment to diversity may be seen in the taskforce set up to promote work-life balance (Howard, 1990). The constitution and the working of this taskforce provided a good example of diversity in practice. Though the CEO was a member of the taskforce, he didn't always play a leading role. Haas showed a rare humility in a CEO when he acknowledged that his perspective on work-life balance was limited and that the variety and breadth of opinion represented on the taskforce helped the company make better decisions: 'After all, my family situation is about as traditional as it gets. I have a wife at home who looks after our daughter. What do I know about the problems of a sewing machine operator - expected to punch in at a certain time and punch out at another and with a half-hour lunch break - whose child's day-care arrangements fall through that morning? Obviously, a better result is going to come out of a broad task force that represents a diversity of opinions, family situations, and points of view' (Howard, 1990; p. 13). Thus, the taskforce drew upon staff from all levels of the organization, and included sewing operators, secretaries, senior managers, a division president and the CEO to have that breadth of views which enables fair and truly informed decision-making (Howard, 1990).

Another example of the company's drive to live by its core values of inclusion and empowerment may be seen in the way it went about a massive $500 million re-structuring of its product development and distribution systems (Mitchell and O'Neal, 1994; p. 3-4). Over 6,000 of the company's 36,000 employees were consulted on how processes could be organized more efficiently. Subsequently, nearly 200 senior managers were assembled and they spent over one year planning the new systems at a cost of nearly $ 12 million. The company's Diversity Council, the body representing African Americans, Asians, Hispanics, women and homosexuals was asked for its input (Mitchell and O'Neal, 1994).

Due to its inclusive nature, the process took much longer and involved more people than would have been the case in earlier times when the company was less particular about abiding by its values. Andersen Consulting, the external advisors to the company during the re-configuration advised against seeking feedback from so many people. However the CEO, Robert Haas, remained steadfast to his aim of being true to company values and being genuinely participatory. He strongly believed that the values-based strategy and the unity and common purpose it would foster would pay dividends in the long run (Mitchell and O'Neal, 1994).

Levi's attempted to extend the reach of its values not only to the managers but also the blue-collar workers, the operators in its sewing and finishing plants who constituted 75 % of the workforce of the company (Howard, 1990). Haas tried to align the treatment of the company's blue-collar workers with the company's aspirational values. He recounted an example of a pilot involving the implementation of the value of empowerment at a manufacturing plant (Howard, 1990). Sewing machine operators were given the autonomy to run the plant as they saw fit provided that they were able to meet pre-agreed production targets, safety standards and absenteeism rates. The management offered to share any net gains on a 50-50 basis with the employees of the plant.

Before this arrangement, this plant was a good producer and ranked among the top 10% in the company (Howard, 1990). After employees were given the reins, the plant rose to become the No. 2 plant in the United States after only nine months of the gain-sharing programme. Haas was pleased by this development, not only because of the financial and productivity gains to Levi's, but also because of the transformation in employee behaviour that took place. The sewing machine operators felt more valued for their contribution to the company's success, and demonstrated initiative instead of waiting passively for orders because they could see the benefits to themselves of acting with a more entrepreneurial, employee-owner mindset. Thus, extending the application of the company values to its blue-collar workers paid off handsomely for Levi's (Howard, 1990).

The company's commitment to ensure fair working conditions for the people employed in its overseas factories was evidenced by its decision to withdraw $40 million worth of business from China because of human rights violations by its Chinese suppliers (Mitchell and O'Neal, 1994; p. 3). To bring its international sourcing operations in line with the International Labour Organization's (ILO) policy on child labour (which prohibits employing children under the age of 14), it enforced ILO guidelines and applied pressure on two suppliers in Bangladesh to stop

employing children under 14 (these suppliers had been employing 11, 12 and 13 year old children). Further, to assist the families of these children who would have been financially affected by their being discharged from employment, the company reached an agreement with its local suppliers wherein the suppliers continued to pay the children's wages until they turned 14 and Levi's paid for their schooling, uniform, books, etc. (Mitchell and O'Neal, 1994; p. 5-6).

3.4.5 Value 3: Empowerment through Technology

Levi's leveraged the power of technology to achieve closer alignment between the company's values and practices (Howard, 1990). At Levi's, the use of technology flowed from and supported the company's code of values, the Aspirations Statement. As part of its value of *empowering* its staff, Levi's attempted to support its people in every way possible. One of the ways in which Levi's tried to support its employees was by ensuring that they had access to the best, most relevant technology for their needs. Levi's drive to utilise the full potential of technology to support its staff was reflected in the way it integrated its technology strategy with its business strategy (Howard, 1990).

Bill Eaton, the company's Chief Information Officer, was a member of the executive management committee and, was, thus, able to provide technological input into business decisions at the highest level (Howard, 1990). His presence helped ensure that business decisions meshed with technological decisions, and that technology was used in the most effective way to support the company's efforts. The Information Technology (IT) team worked closely with the Human Resources (HR) department to harmonise the development of the company's IT platform with the company's evolving business plans, organizational re-configurations and people development needs. One HR manager was assigned to work within the Information Systems team to coordinate the efforts of the two teams (Howard, 1990).

Some of Levi's values were 'commitment to the success of others', 'teamwork', and 'trust'. These values extended not only to the organization's employees but also to its partners, the

suppliers and retailers. Howard (1990) cites an example of how Levi's put these values into practice by harnessing technology to transform its supply chain with retailers. Realizing the need to make its operations more flexible and responsive to ever-changing fashions and fast-moving consumer demand, Levi's pioneered the application of computer networks to establish closer, more finely tuned relationships with its suppliers and retailers (Howard, 1990).

Previously, to ensure the availability of a particular kind of jeans, retailers had to predict the fashion tastes of highly fickle consumers four to five months in advance and, accordingly, make commitments to Levi's to order certain quantities of that product. The problem was that fashion trends were capricious, subject to a wide range of unpredictable influences and susceptible to rapid changes in the interim period. As Howard (1990) describes it, a new movie might come out and make black denim more fashionable and cool than blue denim. This rapid shift in consumer tastes could cause the retailer to be stuck with a product that its consumers no longer wanted and not have enough of the product that they did want. This forced retailers to reduce their prices significantly which hurt their profitability (Howard, 1990).

To respond to this challenge, Levi's pioneered the Levi-Link electronic data-interchange system which enabled them to communicate with retailers much better and to fulfil orders from retailers more quickly and accurately than was permitted by earlier systems. Howard (1990) describes how the system works: 'The system collects point-of-sale information from cash registers at the company's major accounts, then uses the information to generate reorders, invoices, packing slips, and advance notifications to retailers of future shipments. It also provides company sales representatives with far more information on the activity of individual retailers than was available in the past' ((Howard, 1990; p. 9-10).

By introducing the Levi-Link system, Levi's was able to help its customers, the retailers, carry less inventory (20 % to 30 %) (Howard, 1990). Retailers were pleased because they had stock for the products that their customers desired, and were, therefore, able to offer a better service and experience to their customers. Consequently, their sales went up significantly (20 % to 30 %). Since the retailers' return on their investment with Levi's increased, the relationship was strengthened (Howard, 1990). CEO Robert Haas viewed this symbiotic relationship with

suppliers as a necessity to meet the challenge of satisfying the needs of ever more demanding and discerning end customers. He argued for the need to transform working relationships with partners to create 'a seamless of mutual responsibility and collaboration'. He asserted that keeping pace with the new developments in fabrics and the rapidly changing tastes of customers required greater closeness, better exchange of information and more collaborative working relationships between Levi's and its partners at every step along the supply chain (Howard, 1990).

Another instance of the use of technology to achieve congruence between values and practices was in relation to the value of *empowerment* (Howard, 1990). Eaton, the company's Chief Information Officer, said that 'empowerment is meaningless unless people have access to information. The goal of our technology strategy was to make sure that the information was available on the desktop of the person who is doing the job' (Howard, 1990; p. 9). To ensure the timely and easy accessibility of information, Levi's made significant investments in information technology to integrate its operations. Manufacturing was computerized; each pair of jeans that was sewed was immediately scanned into the system through its bar code. This not only enabled the person sewing the garment to keep track of their performance, thereby, giving them vital information to increase their productivity, it also enhanced the flow of useful information all along the way. This system enabled the company to monitor 'work-in-process' and establish a 'real time production control system' (Howard, 1990; p. 10).

By linking this system with Levi-Link, the company was able to generate new production orders to replenish stock for products as soon as they were sold by retailers (Howard, 1990). Further, through this system Levi's staff were able to obtain detailed and in-depth information on sales from the retailers' systems. Levi's employees were able to know not only which products were selling but also sizes, fabrics and styles. As a result, they were able to plan for the store's needs and adjust their production levels better. The result was significantly reduced wastage and obsolete inventory, improved customer experience, increased profits, and greater trust between the partners (Howard, 1990).

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As well as generating lots of new information by bringing together several different sources of information through the new IT systems, Levi's also increased access to information (Howard, 1990). Non-managerial staff were now able to perform powerful, flexible and customisable searches according to their requirements. In the past, access to this information was restricted to managers. However, in the spirit of its value of empowerment, the flow of information was democratised and more staff given information suitable to their needs (Howard, 1990).

3.4.6 Training in Values

To further entrench the values, Levi's developed a more extended and comprehensive training course to inculcate the organizational values among its managerial staff (Howard, 1990). Called 'The Core Curriculum', this week-long programme trained staff with leadership potential in practising the values in the Aspirations Statement. Offered about twenty times a year, with groups of approximately twenty participants, by 1990, this training was attended by the top seven hundred managers in the company. A member of the executive management committee (the top eight people in the company) or a senior manager was always present at these courses to indicate the seriousness with which the company expected this training (and, by extension, the importance of company values) to be taken (Howard, 1990).

The reach of this training in living the company values didn't end with attendance on the course (Howard, 1990). The reflection on company values and their application in everyday practice encouraged by the course often stimulated participants to raise questions and concerns about the way the organization operated. These questions were collated by the human resources team and reported quarterly to the executive management committee. The committee deliberated on these questions and sometimes, as a consequence, suggested organizational changes to create better alignment between organizational values and actual operational practice. The course kick-started a vigorous dialogue around values in the company, and created a positive feedback loop between middle and senior management. It initiated a conversation between the operational managers who executed policy and who knew where misalignments and mismatches between values and practice occurred and the senior managers in the organization who took policy decisions, and who had the influence to change the organization in a significant

way. It helped in countering cynicism and obtaining buy-in from employees who realised that the company was sincere about practising its values. The training and the resulting discussions assisted in embedding the values in daily operational practice and made them more effective (Howard, 1990).

3.4.7 Challenges in Following a Values-Based Strategy

However, the process of living by the organizational values was not an easy or happy one for all employees (Mitchell and O'Neal, 1994). The move to make promotional opportunities fairer for ethnic minorities upset some white employees who felt that their prospects for advancement were retarded as a result. However, Haas countered this by saying that merit was henceforth to be the main criterion in determining who obtained promotions and who didn't: '[For white males] who focus on self-improvement and their contributions, the chances are good. We've eliminated the automatic promotions based on the old-boy network' (Mitchell and O'Neal, 1994; p. 4).

The transition to greater, autonomy and responsibility, as required by the company value of empowerment, was difficult for many employees who were used to the old order and who struggled to change to the new system. As Mitchell and O'Neal state, 'Empowerment and teamwork can be alien, uncomfortable concepts for those who have spent their working lives taking orders' (1994; p. 5).

The preceding section examined the role of organizational values in driving alignment between an organization's stated ethical standards and its actual behaviour. Some of the challenges in doing so were discussed. The next section takes up another important structural factor that exercises a strong influence on the ethical culture of an organization – organizational mission. Through an example, the effect of organizational mission on ethical culture is explored.

3.5. Organizational Mission and Ethics

Trevino and Brown (2004) cite the history of Arthur Andersen as an example of how a change in an organization's mission can result in new ethical tensions and conflicts which can, ultimately, as they did with Arthur Andersen, bring the organization down. This has relevance for healthcare providers, especially, NHS Trusts and social enterprises as they broaden their mission from providing a public service to also becoming profit-maximizing organizations. Arthur Andersen had a solidly ethical culture, inspired by the ideals and high ideals of its founder. Clients of the multinational firm knew that irrespective of which part of the world they were operating in, they would receive the same professionalism, high standards of quality and integrity from Arthur Andersen employees. The company had a strong ethics training programme and all new hires were inducted into '*The Andersen Way*'; 'Partners said with pride that integrity mattered more than fees' (Trevino and Brown, 2004; p. 74). So robust was the firm's reputation for ethics that it had a consulting arm that advised other organizations on how to be ethical.

The downfall started when the organization began to emphasize the more lucrative management consultancy side of its business. Arthur Andersen's core business was auditing accounts, and its ethical systems had been designed for an auditing culture. Management consulting and auditing, argue Trevino and Brown (2004), are very different kinds of businesses, with their own cultures and ethical requirements. As the management consulting business generated more profits, it began to dictate the culture of the organization. The ethical systems that had worked well for auditing did not fit the requirements of management consulting. While a clear, coherent, and comprehensive ethics strategy had been formulated for the auditing business by the firm's founder and subsequent leaders, a similarly well-thought-out, sound ethics plan was not put in place for the rapidly expanding management consultancy business. As a result, ethical violations began to emerge in the consultancy business. The organization's ethical fabric had begun to unravel.

What added to the already fraught situation is that, often, Arthur Andersen offered both auditing and management consultancy services to the same client organizations (The Wall Street Journal, June 7, 2002). Tensions and conflicts of interest began to emerge between the

two arms. These contradictions were not addressed. The contagion began to spread, and unethical practices became more and more commonplace in both the auditing and management consultancy arms. To give one example, consulting costs were *padded*, i.e., wilfully increased manifold, and junior staff were bullied and coerced into supporting these extravagant, unjustified and unethical increases (Toffler and Reingold, 2004; also, Bloomberg, March 17, 2003).

The transition from an organizational focus on auditing to management consultancy resulted in a growing fixation with profit generation and a dilution in the ethical standards. As management consulting gained priority in the organizational leadership's eyes, the practices of the organization began to be oriented around it, to support it. For example, in the past, all new employees, including experienced professionals hired from outside, were required to attend the company's three day induction and training session which socialized them into the Arthur Andersen values and ways of working. The training used to be considered sacred (Trevino and Brown, 2004). However, increasingly, experienced consultants were allowed to skip the training so as not to give up profitable consulting work.

Complacency over ethics grew as ethics increasingly disappeared from discussions within the company. The vestiges of the firm's illustrious ethical past still existed but had largely become irrelevant to the new culture of the organization: 'The firm still had a huge maroon ethics binder, but no one bothered to refer to it' (Trevino and Brown, 2004; p. 75). When Barbara Toffler, a professor of business at Harvard Business School and an ethics consultant who had been hired by the company as the head of the Ethics and Responsible Business Practices Group, raised the subject of ethics at a meeting, she was 'looked at as if I had teleported in from another world' (Trevino and Brown, 2004; p. 75). It was taken for granted that all the staff who joined the company had been selected for their sound judgment and ethical values and were, therefore, automatically ethical in their practice (Trevino and Brown, 2004).

Over time, the gaps between ethical policy and practice began to widen, and eventually resulted in the collapse of the organization as it was mired in several accounting scandals around firms it had audited accounts for (Toffler and Reingold, 2004). This is a salutary example of mission

creep, and of how a change in an organization's mission can contribute to the erosion of its ethical culture unless ethical issues are addressed explicitly and squarely. Social enterprises might be at a slight disadvantage in this respect as NHS Trusts at least have designated ethics offices and individuals to identify ethical issues growing from the new organizational purposes, whereas social enterprises showed a relative lack of clearly named and designated ethics officers or teams.

This section showed how the corrosion of an organization's mission can lead to unethical behaviour. The next section extends this theme by analysing the role of organizational goal-setting processes on its ethical culture. The ways in which an over-emphasis on the achievement of goals and an under-emphasis on the means used to attain those goals can lead to unethical behaviour are described.

3.6. Organizational Goals and Ethics

Vidaver-Cohen (1998) suggests that organizational goal-setting processes are an important influence on the ethical culture of the organization (also, see Passas, 1990). Certain kinds of goal-setting processes, she argues, increase the likelihood of unethical conduct. For instance, a single-minded, exclusive focus on one goal (a goal not related to ethical behaviour) by an organization, especially one that has multiple stakeholders (such as a public healthcare provider) could result in negligence of the organization's duties to its other stakeholders, and possibly, even harm (Hosmer, 1994). Evidence from several studies suggests that organizations that encourage and reward the achievement of goals without giving due importance to the methods used to achieve those goals (the *win at any cost* mentality), that over-emphasize the outcome and under-value the process, that valorize the attainment of the ends but are silent about or neglect the employment of the right means are more prone to ethical misconduct (Cohen, 1993, 1994, 1995; Passas, 1990).

Employees in many organizations are often subjected to tremendous pressure by their superiors to achieve organizational goals (McCuddy et al., 1993). As Chen et al. (1997) note, 'The

outcome focus of management by objectives sends a message to middle managers that what is important is achieving those outcomes, regardless of *how* it is done' (p. 860). Often, the pressure to meet targets and the fear of sanctions leads managers to dilute or sacrifice their ethical principles at the altar of corporate success (Jackall, 1988). When faced with ethical dilemmas, some choose the path of silence to avoid the unpleasant consequences of questioning their superiors' actions (Chen et al., 1997). This reflects a change in the understanding of management from a fundamentally moral activity involving the confrontation of serious and thorny moral dilemmas to that of a value-neutral, exclusively technical practice (Chen et al., 1997; also, see Francis, 1990). Buchholz (1989), however, argues that 'ethics is central to the managerial task' (p. 28).

A highly important factor that affects the likelihood of employees engaging in unethical behaviour, claims Kaptein (2011), is the relationship between the ends mandated by the organization and the means at the disposal of employees to achieve those ends. Kaptein argues that a scarcity of means in relation to mandated ends can increase the likelihood of unethical behaviour. For instance, if employees feel that they do not have enough time, money, manpower, equipment, information, authority, etc. to achieve the goals set by the organization, they might experience ethical dilemmas (also, see Schweitzer et al., 2004). This argument draws upon Strain Theory (see Merton, 1938) which proposes that people engage in unethical behaviour when they believe that they cannot achieve their goals through fair and socially approved means.

Trevino (1986) amplifies this idea by suggesting that employees who are put under severe time pressure are less likely to be punctilious about ensuring that their approach is ethical and more likely to compromise on ethics than employees who are given sufficient time to perform their tasks. A high-pressure culture coupled with a significant imbalance between ends and means, proposes Trevino, encourages employees to consider achieving the ends (meeting financial targets or completion deadlines) much more important than being ethical in one's methods and to rationalise away any ethical qualms they may have. Such cultures, she claims, create situations that are ripe for ethical lapses to occur.

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Ahmed and Machold (2004) suggest that a chronic emphasis on the short term can tempt organizations to jettison moral principles for easy profits. Though the ethical route might prove costly in the short term, in the long term the organization is likely to reap the gains of its ethical behaviour. Their view is supported by Collins and Porras (1994) who found evidence that enduringly great companies tended to work with very long time spans of decades and sometimes, centuries, and (with a few notable exceptions such as tobacco companies) also tended to have strong ethical underpinnings.

The preceding section investigated the impact of organizational goal-setting processes on ethical culture and suggested that if an emphasis on goals is not balanced with a strong insistence on the use of correct means, conditions favourable to unethical behaviour can be created. The next section examines the influence of incentives and reward systems on the ethical cultures of organizations. One of the most potent weapons in the armoury of leaders looking to shape the cultures of their organizations, incentives and reward systems exercise a powerful influence on ethical behaviour.

3.7. Incentives and Reward Systems and Ethical Culture

Organizations shape employee behaviour through their system of incentives and disincentives. Incentives may be monetary, such as salary increases, cash bonuses and prizes, vouchers, stock options, employee profit-sharing plans, etc. and non-monetary such as promotions, public recognition and praise, such as *Employee of the Week / Month / Year*, tickets to sporting or musical events, etc. (James, 2000; p. 46-47).

The ability of the organization's incentive system to influence ethical behaviour has been documented in a number of studies (Metzger et al., 1993; Trevino and Nelson, 1995; Jansen and Von Glinow, 1985; Kerr, 1975; Hegarty and Sims, 1978; Worrell et al., 1985). As Kerr (1975) states, 'most [workers] seek information concerning what activities are rewarded, and then seek to do (or at least pretend to do) those things, often to the virtual exclusion of activities not rewarded. The extent to which this occurs of course will depend on the perceived

attractiveness of the rewards offered.' (p. 769). The broad conclusions of this literature are that organizations tend not to reward ethical behaviour because such actions tend not to be highly visible or measurable but do discipline and discourage unethical behaviour (Trevino, 1990; Brooks, 1989). Unethical behaviour tends to increase when it is rewarded and decrease when it is punished (Hegarty and Sims, 1978; Worrell et al., 1985; Laczniak and Inderrieden, 1986). Also, poorly designed compensation systems can sometimes have perverse effects and inadvertently encourage behaviour different from that which is intended. As Kerr (1975) explains, 'Numerous examples exist of reward systems that are fouled up in that behaviours which are rewarded are those which the rewarder is trying to discourage, while the behaviour he desires is not being rewarded at all' (p. 769).

Trevino and Brown (2004) assert that the organization's reward system is, arguably, the single most powerful organizational influence on the ethical behaviour of employees. Drawing on the behavioural psychological theories of B. F. Skinner (Skinner, 1938, 1972), Trevino and Brown contend that behaviours which are rewarded tend to get repeated and increased in scope and those which are punished tend to decrease, diminish in intensity, weaken and die out. The relevance of this for ethical culture is that for an ethical culture to be sustained it is imperative that ethical behaviour be rewarded and unethical conduct be punished.

An important factor that impacts whether employees behave ethically or not is the kind of behaviour - ethical or unethical - that is rewarded by the organization (Kaptein, 2011). This proposition is based on Reinforcement Theory (Falkenberg and Herremans, 1995) which states that the consequences of an action (i.e., the response that an action draws from others) determine whether that action is likely to be repeated or avoided in the future. Actions that are rewarded are more likely to occur again; actions that are punished are likely to be avoided. The significance of Reinforcement Theory for ethical behaviour is that employees will consider the likelihood of being rewarded by the organization for ethical behaviour and being punished for unethical behaviour in deciding which kind of behaviour they choose to engage in. So, if employees know that unethical behaviour will invite disciplinary measures and that the cost of such behaviour will outweigh any potential gains, they will refrain from misconduct (Cressey, 1953).

On the other hand, if unethical behaviour is not discouraged, or is rewarded, then, the perpetrators (and other employees who see this) will be strengthened in their belief that in this organization, unethical behaviour is accepted, that breaking the ethical rules pays off (Ball et al., 1994). Kaptein (1998) found that in some organizations the warning signs had been there in the form of milder ethical infractions. However, the ethical violations were not punished even after being detected. As a result, unethical behaviour continued and got worse.

Kaptein (2011) argues that the absence of penalties for breaches of the organization's code of ethics is one side of the coin. The other side of the coin is the lack of appreciation for ethical behaviour. Reinforcement Theory suggests that behaviour which is reinforced through appreciative feedback, encouragement, recognition and rewards is strengthened and likely to be repeated. However, if good behaviour does not receive reinforcement, the motivation to perform the behaviour is weakened. Both Kaptein (2011) and Roman and Munuera (2005) found that when ethical behaviour was appropriately reinforced, instances of misconduct dropped appreciably, and where it was not reinforced, the incidence of misconduct was higher.

Rewards and punishments are significant motivators of ethical and unethical behaviour. The proposition that rewarding unethical behaviour increases the likelihood of its being repeated in the future is a fairly intuitive one and is supported by a considerable body of evidence (Ashkanasy et al., 2006; Hegarty & Sims, 1978; Tenbrunsel, 1998; Tenbrunsel et al., 2003; Trevino & Youngblood, 1990). While it would seem logical and commonsensical to expect a similar relationship between rewards and ethical behaviour to obtain, the actual relationship is not as straightforward as one might suppose. Rewarding ethical behaviour, particularly through financial incentives, instead of reinforcing and encouraging such behaviour, has been shown to actually discourage such behaviour. Research from economics and social psychology reveals that contrary to the expectation that a self-interested, utility-maximizing individual would be more likely to engage in pro-social, altruistic behaviour when paid for it, paying people for such behaviour actually reduces the likelihood of their engaging in it (Trevino et al., 2006).

Economists explain this paradoxical observation by arguing that the extrinsic monetary reward for voluntary altruistic acts 'crowds out' the intrinsic motivation (the inner gratification, the satisfaction of doing something because it is the right thing to do, the purity of motive, the pleasure of doing a good deed disinterestedly and for its own sake) (Frey & Oberholzer-Gee, 1997; p. 746-747; Gneezy & Rustichini, 2000). Psychological theories of identity formation suggest that people engage in altruistic behaviour because it is congruent with and reinforces their 'moral identity', their perception of themselves as a good person (Trevino et al., 2006; p. 962-963). Monetary compensation for a good deed, thus, denies them the boost to their identity and their sense of being a good person, thereby, decreasing the desire to behave ethically in the future (Brekke et al., 2002). Therefore, financial rewards can sometimes backfire and decrease motivation to engage in ethical behaviour. The organization, thus, has to decide judiciously when to use, and when not to use, financial incentives as rewards for ethical behaviour (Trevino et al., 2006).

While employees may not expect to be rewarded for ethical behaviour, they do expect not to be punished or affected adversely for acting ethically (Trevino and Ball, 1992; Trevino et al., 1999). Moreover, their beliefs about fairness may demand that others who behave unethically will be appropriately disciplined (Trevino, 1990; Trevino & Ball, 1992; Trevino & Weaver, 1998). If employees who were originally disposed to behave ethically are disappointed in their expectation of fair treatment by observing the organization's failure to punish ethical violators, their disillusionment and scepticism about the organization's ethical intent may lead them to engage in unethical behaviour themselves (Van den Bos et al., 1997; Trevino et al., 1999).

Since there is a societal expectation that people should behave ethically, and since most employees expect to behave ethically, rewarding ethical behaviour, at least in the short term is not so straightforward. Most people don't expect to be rewarded just for doing their jobs, and take ethical behaviour to be a part of their job. Trevino and Brown (2004), however, suggest that in the longer term it is possible to reward ethical behaviour by promoting those who are exceptionally high performers *as well as* highly ethical. They propose that only those employees who demonstrate great integrity and who are, thereby, able to build relationships of trust and respect with their co-workers, customers, superiors, subordinates, etc. be considered for promotions.

By making ethical behaviour an important and explicit criterion in performance evaluation and for advancement in an organization, a clear signal can be sent that ethical behaviour pays off in that organization. Such a promotions policy communicates to employees that success and advancement in this organization require both high performance *and* highly ethical behaviour, that both the bottom line *and* ethics count, and that it is not possible to succeed and advance without having both (Trevino and Brown, 2004).

Another mechanism Trevino and Brown (2004) suggest is to reward ethical conduct more directly by incorporating it into compensation systems and by offering incentives, financial and non-financial, for exceptional and exemplary ethical behaviour. They cite the example of Lockheed Martin, a large American manufacturer of military aircraft and defence systems, which honoured the most outstanding instance of ethical behaviour in the past year with the 'Chairman's Award' (p. 79). All senior corporate leaders were expected to identify examples of ethical best practice in their respective departments and nominate employees for this award. Trevino and Brown argue that such a 'ritual' has value in creating an ethical culture. This event was attended by all the senior corporate leaders. Ethical issues were discussed; stories of heroic ethical practice were shared and became part of the organization's lore. The cumulative impact of such an event year after year was to strengthen the moral fabric of the organization (Trevino and Brown, 2004).

While the first insight of behavioural psychological theories is that rewarding behaviour increases the likelihood of its recurrence, the second insight is that behaviour that is not reinforced or punished tends to be weakened and dies out. The implication for creating an ethical culture is that fair-minded employees expect unethical behaviour to be disciplined (Trevino and Brown, 2004). Nothing can frustrate, disillusion and demoralise honest employees as seeing ethical violators get away scot-free, or worse, be rewarded for unethical conduct.

The rewarding of unethical behaviour was one of the original causes of Arthur Andersen's downfall. As a management consulting culture took hold, and income generation became the primary focus, those employees who were able to bring in revenues were rewarded, regardless of how they achieved this. As attention was not paid to the methods that employees were using to achieve their goals, tacit acceptance or encouragement was extended to consultants who stretched out their contracts using any means necessary (as Toffler and Reingold (2004; p. 123) put it, 'Consultants were taught to check in, but never check out'), over-billed clients and 'screwed' their more honest colleagues who were unwilling to be party to this deceit (Trevino and Brown, 2004; p. 79).

Creating an ethical culture requires that ethical offenders meet with swift retribution, particularly, if the violator is a senior member of staff or a high performer. The punishment of senior employees or high-performing, *star* employees for deliberate unethical acts, suggest Trevino and Brown (2004), sends a strong message down the organizational chain that misconduct is not tolerated and that the senior leadership will not connive knowingly in ethical violations. Further investigation should examine, they add, whether the violation was due to an individual's bad intent or whether there were wider, more systemic factors at work that were responsible for aiding and abetting the individual's wrong behaviour.

To illustrate the role played by flawed compensation and reward systems in encouraging unethical behaviour, Paine cites the example of Sears Auto Centers, the automotive service business of Sears, Roebuck & Company (a large and well-known American company). Sears Auto Centers was sued by customers and attorneys general in 40 states for having mis-sold customers unnecessary automotive parts and services. The subsequent litigation cost the company an estimated $ 60 million. An investigation by the company revealed that the cause lay in the new performance targets and incentive systems introduced by the management. Faced with declining market share and falling revenues, the management had responded by setting product-specific quotas for various automotive parts and incentivised sales advisors by offering commissions on sales. Failure to meet quotas could lead to serious penalties such as reduction in working hours (effectively, a reduction in income for sales personnel). While this practice of setting sales targets and offering bonuses and commissions is in itself quite routine and commonplace, its significance for unethical behaviour lay in the degree of pressure applied on

sales staff by their bosses: 'Some employees spoke of the "pressure, pressure, pressure" to bring in sales' (Paine, 1994; p. 107). Facing tremendous pressure to meet their sales targets, and feeling increasingly that they could not achieve their targets through fair means, some sales advisors may have been tempted to resort to unethical methods to achieve their quotas.

To compound the problem, there was inadequate organizational support for ethical behaviour and poor oversight of the methods used by sales staff. The lax performance monitoring systems allowed poor or unethical practice to go unnoticed or, if noticed, to go without inviting disciplinary action. The contextual cause of unethical behaviour, in this instance, appears to be the combination of a performance management and incentive system which set highly ambitious targets that were enforced with sanctions for those who did not meet those targets, and poor performance monitoring that failed to keep misconduct under check. Following the investigation, this performance management and incentive system was scrapped and surprise inspections and audits were introduced to detect violations of company policies.

In this section, the role of incentives and reward systems in shaping the ethical behaviour of employees was discussed. The next section continues this discussion and examines in more detail the effects that performance evaluation processes have on the ethical cultures of organizations.

3.8. Performance Evaluation Processes and Ethical Culture

Performance evaluation processes constitute another important structural influence on ethical behaviour (James, 2000). As James suggests (p. 48-49), the ways in which the performance and actions of individuals or groups of individuals is defined, measured and evaluated has a very strong impact on the behaviour of employees. Performance evaluation systems shape employees' perceptions of what is expected of them (James, 2000). It is important that as organizations become larger and the interactions between different parts of the organization become ever more complex, performance evaluation processes become more sensitive to their power over employees' ethical behaviour (Vaughan, 1983).

If performance evaluation processes are ineffective due to poor design or implementation, they may encourage unethical behaviour, either indirectly by not identifying unethical behaviour and, therefore, unintentionally supporting it, or directly by applying pressures of various kinds that incline employees' towards unethical conduct (James, 2000). Performance evaluation processes that are unable to detect ethical violations or that limit themselves exclusively to assessment of performance without also considering the methods by which the performance was achieved open the door to unethical behaviour. Such inadequate performance evaluation systems may create a false impression in employees' minds that the organization endorses such unethical behaviour, or that such ethical violations are necessary to achieve organizational goals and are, therefore, acceptable (James, 2000).

White and Lam (2000) propose making ethical behaviour an integral part of the performance evaluation system for all employees as a way of demonstrating the importance that the organization places on ethical behaviour. This would, they claim, establish a clear, visible link between ethical behaviour and organizational success, and send a clear message to all employees about the kinds of behaviours that the organization values. They further propose not only making compensation arrangements contingent on adherence to the organization's ethical policies, but also actively rewarding employees, monetarily and non-monetarily, for ethical behaviour, thereby, reinforcing such behaviour. Incorporating assessments of ethical behaviour as a formal criterion into the performance evaluation process for all employees, they suggest, is likely to motivate employees to behave ethically (White and Lam, 2000; p. 41).

James (2000) suggests that performance evaluation processes can give rise to ethical tensions when they do not pay due regard to the process by which individual and organizational performance targets are achieved. It is not enough, according to James, to set performance goals for individuals. It is a job half done without a simultaneous articulation of how those targets are to be achieved and what behaviour is considered acceptable and unacceptable in the pursuit of those targets. In his view, the organization ought to make it clear that unethical behaviour in an attempt to achieve the organization's goals will not be tolerated or rewarded. The absence of a clear statement of the unacceptability of unethical behaviour even when it

leads to the achievement of individual and organizational goals tacitly supports unethical conduct and creates conditions in which such behaviour is likely to emerge. To avoid this problem, James recommends that the organization make it clear that only ethical means are acceptable, and that the ends do not justify the use of wrong means.

Ways of ensuring that performance evaluation processes support ethical conduct and not undermine it include the following. The use of coercion and the threat of sanctions or ultimatums by superiors to enforce the achievement of individual and organizational performance targets at any cost can undermine ethical behaviour, and must be avoided (Jones and Ryan, 1998; Carroll, 1975, 1978; Paine, 1994). Also to be avoided is ambiguity regarding the means of achieving organizational goals. James gives an example of how this can be done. If a senior manager says only that 'Profit is the over-riding objective of this team (or unit)', then, his or her subordinates might interpret it to mean that profits much be achieved at any cost. To counter this erroneous impression, it should be made clear that the methods to be used to achieve performance goals are equally important, and that the methods used to achieve profitability must comply with the organization's ethics policy (Trevino and Nelson, 1995). Clear moral guidance, according to Vidaver-Cohen (1998), is an effective aid to ethical behaviour. Vigilant and vigorous monitoring of performance, early detection of ethical infringements, appropriate disciplinary action, and removal of obstacles or barriers to ethical behaviour are other ways of ensuring that performance evaluation systems reinforce ethical behaviour (Trevino and Nelson, 1995; Vidaver-Cohen, 1998).

Lack of vigilance by superiors and lax performance monitoring (even of past good performers, and of isolated cases or individuals) can allow unethical behaviour to go unnoticed for long periods of time, thereby, making things worse and sometimes posing grave risks to the very existence of the organization (James, 2000). For example, the London-based Baring Bank was brought to its knees by the actions of a single rogue trader, Nick Leeson, who broke company protocol about securities trading and escaped detection by altering company records. He had accumulated losses totalling $ 1.4 billion by the time his fraud was detected, bringing Baring Bank to the brink of insolvency. Leeson had been a good performer for the organization in the past which, perhaps, explains why his actions were not scrutinized more closely by his superiors and why he was able to perpetrate the fraud for so long (Brickley et al., 1994).

One solution to this problem proposed by James (2000) is to monitor on an ongoing basis the effects of organizational incentives and pressures on the ethical conduct of employees and, should an organizational incentive have the undesirable side-effect of encouraging unethical behaviour, to take corrective action. The corrective action may take the form of re-designing organizational incentives (if the problem lies on the organizational design side) or coaching the employee (if the problem lies with the behaviour of the individual employee). The key, suggests James, is to be alert to even small ethical infractions, to catch them early and correct them, thus, preventing them from snowballing into crises. An additional step that senior leadership could take is to ensure that organizational objectives are compatible with the stated ethical standards of the organization, i.e., the organization's goals should be achievable by ethical means and should not be such that employees face the dilemma of either being ethical and not meeting the goals or meeting the goals but only by resorting to unethical means. Consistency in maintaining ethical standards throughout the organization needs to be a major focus for senior leadership, suggests James.

At Martin Marietta Corporation, an American aerospace and military equipment manufacturer, ethically responsible behaviour was an explicit criterion in performance reviews. Both means and ends are ends were kept in view in performance appraisals (Paine, 1994; p. 112, 114). Employees had to ensure that their behaviour in pursuit of professional goals was consistent with the company's ethical standards. Performance reviews took account of employees' ethical conduct and the degree to which they shared and manifested their organization's ethical values. To be eligible for incentives, senior executives had to take personal responsibility for promoting ethical conduct among their charges (Paine, 1994; p. 114).

The previous section looked at performance evaluation processes and how they support or undermine ethical behaviour. The next section examines codes of ethics and analyses their strengths and limitations in helping to create an ethical culture. Some implications for public and private organizations are drawn out.

3.9. Decision-making Powers and Ethical Culture

In addition to organizational rewards systems and performance evaluation processes, a structural element that exercises a potent influence on ethical behaviour is the extent of decision-making responsibilities and rights enjoyed by employees. James (2000) proposes that the decision-making power of an individual employee may be assessed along two dimensions: a) the range and variety of responsibilities that the employee enjoys; an employee may deal with a small and limited number of highly specialised, focused tasks, or they may general, wide-ranging, multiple responsibilities, b) the scope or room for active influence by the individual worker over the tasks; in a decentralised structure, the employee will have a lot of freedom whereas in a centralised structure they will have very little freedom.

James gives two examples to illustrate this point: a clerical worker may deal with a wide range of general tasks but have little influence over the process or the outcome of those tasks; in contrast, a salesperson's role may involve a narrow range of highly focused and specialised tasks – to sell a product to a prospective customer – but the salesperson may have a lot of room for personal choice and a lot of freedom in how they choose to do their work to achieve the end goal of a sale (James, 2000; p. 50). The relevance of this distinction to ethical behaviour, as James explains, is that the range and variety of tasks that an employee is entrusted with and the degree of control they are given over these tasks determines the kinds of ethical tensions that they are likely to encounter. Therefore, to facilitate ethical behaviour, the organization needs to ensure that the decision-making powers that employees are given are commensurate with the ethical challenges that their role/s are likely to throw up. When their roles present ethical dilemmas, employees must have the necessary authority to make appropriate ethical decisions (James, 2000).

As indicated previously, organizations' incentive structures and performance evaluation processes can put pressures on employees to behave unethically. In the face of such pressures, whether an employee behaves ethically or not corresponds, in part, with the degree of freedom that they exercise over their work because it limits or expands their choices and the alternatives for ethical action that they have (James, 2000; p. 51). Some research studies show that

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managers at the bottom of the organizational hierarchy experience the strongest ethical conflicts (Brenner and Molander, 1977; also, see Waters and Bird, 1986, 1987). James hypothesizes that this may be due to their more limited decision-making powers that the junior-most managers enjoy.

It has been suggested above that insufficient decision-making powers can constrain the abilities of employees to act ethically. Additional related barriers to ethical behaviour include inadequate information and the disjunction between those most knowledgeable about an ethical conundrum and those making the important decisions (James, 2000). Regarding the first problem of inadequate information, Jones and Ryan (1998) observe that 'feelings of powerlessness with respect to high level decisions are made worse by limitations on information flows' (p. 440). Extent of information is related to decision-making ability. The organization must not only ensure that the decision-making powers given to employees are proportionate to the ethical challenges presented by their work, it must also arrange for employees to be provided with the necessary information that their role and their particular ethical challenges require.

One way of doing this is to inform employees of the ethical implications and ramifications of their actions. Another is to give employees who have the best understanding of the specific ethical dimensions of a particular issue the authority to make decisions about it (Minkler, 1993; also, see Jensen and Meckling, 1992). The separation between those who know the most about the ethical aspects of an issue and those who make the crucial decisions in relation to it (the second barrier to ethical behaviour mentioned at the beginning of this paragraph) has been the cause of several tragedies (James, 2000).

One of the most highly publicised organizational ethical failures was the mid-air explosion of the American space shuttle Challenger in 1986 which led to the deaths of the seven astronauts on board (Boisjoly et al., 1989). The rocket boosters had a major flaw which the engineers and scientists who had designed the boosters were aware of. The engineers from Morton Thiokol (the private company which had designed the rocket boosters for the shuttle under contract from The National Aeronautics and Space Administration (NASA)), had made their own and

NASA managers aware of this potentially fatal flaw. However, their warnings were ignored, their concerns were dismissed as being over-cautious, and the decision to launch was taken by the management of Morton Thiokol and NASA (Boisjoly et al., 1989). Less than two minutes into flight, the shuttle exploded due to escaping hot air gases, killing the crew instantly. The tragedy occurred because those with the most information and the deepest understanding of the construction of the shuttle, and of its weaknesses, did not have the decision-making power. Their inability to act ethically and stop or delay the launch led to the tragedy (Boisjoly et al., 1989).

A solution proposed by James (2000) to this problem is that organizations should invest those with critical knowledge that is highly pertinent to an ethical issue with the decision-making rights over that issue, and to ensure that they understand the moral implications of their choices and take full responsibility for their decisions. However, a practical difficulty in doing this is that it is often hard for leaders to foresee which ethical issues their subordinates are going to face, and, therefore, to know in advance how much information and decision-making authority they should be given. As a pragmatic compromise, James suggests that, at the least, those who are 'closest' to the situation should be able to voice their concerns to senior leadership, and that their views should be listened to and treated with due respect by the leadership (p. 52).

The previous section investigated the influence of decision-making powers given to employees in shaping the ethical culture of an organization.

3.10. Conclusion

This chapter has explored the various ways in which structural organizational factors shape the ethical culture of an organization. Examples were given of systems and mechanisms that exercise a decisive influence on organizational ethical culture. This chapter began with an overview that showed how the focus of organizational research has shifted from analysing the moral characteristics of individuals who err by engaging in unethical behaviour to analysing the systemic failings of organizations that err by encouraging unethical behaviour explicitly or

tacitly. Following this, a broad overview was provided of common approaches to building ethical cultures. The individual components of ethical cultures were then discussed individually.

The first component to be analysed was leadership. It was argued that the conduct of leaders is a powerful force that guides the behaviours of their subordinates in important ways. Some of the tools and levers that leaders use to direct and channel employee behaviour along the desired ways were discussed. The next section examined the role of one of the most significant of these levers – organizational values. Using a concrete example, the use of values in aligning an organization with its stated ethical principles was analysed. It was argued in the next section that along with values, organizational mission and goals are very important factors that heavily influence the ethical character of an organization, and the ways in which this influence plays out were explored.

Subsequent sections discussed the roles of incentives and reward systems and of performance evaluation processes in shaping employee behaviour and pushing employees towards ethical or unethical behaviour. Codes of ethics were examined in the next section, and their usefulness and limitations analysed. The next section took up the role of decision-making powers granted to employees and suggested that this can have important ramifications for ethical behaviour. Using a specific example, it was shown how not giving employees sufficient decision-making powers can lead to tragic disasters.

<u>Part Two</u>

<u>3.11 Organizational Systems Required to Create an Ethical (Equity) Culture: a British Perspective</u>

<u>Overview of the Section</u>

This section reviews the British literature on organizational systems that can contribute to the formation of an ethical and equitable organizational culture in public healthcare providers in the UK. The key influences on an organization's ethical and equity culture (such as organizational mission, values, performance management systems, etc.) are discussed in this review. A noteworthy feature of this section is that whereas the orientation of the first part of the literature review was towards the international literature, the emphasis of this second part is on the British literature, especially, that centred on the British National Health Service (NHS).

The following section of the literature review focuses heavily on NHS organizations. This is not the result of a conscious or unconscious bias. There is a rationale for this. The Social Enterprises (SEs) discussed in this research project are ex-NHS organizations. The vast majority of the healthcare services provided by SEs are contracted for and financed by the NHS. Even though SEs are independent organizations, the NHS continues to exercise a significant amount of influence on what the care delivered by them looks like. Importantly, in the patients' minds, there is no difference between the NHS and SEs. Many patients (perhaps the majority) believe that they are receiving NHS care even when it is being delivered by a Social Enterprise. Therefore, when a reference is made in the following section of the literature review to NHS care, it should be taken to mean care financed by the NHS; it may be provided by either an NHS or SE provider. Similarly, any references (unless otherwise specified) to NHS staff mean all staff providing NHS-funded care, including staff who work for SEs.

This section opens with an exploration of the role of organizational mission and the NHS Constitution in the formation of an ethical and equitable culture in NHS provider organizations. This is followed by a discussion of the vital importance of NHS organizational values in fostering a culture of care and compassion in the NHS. Caring and compassion are values that are essential to providing equitable, patient-centric, and excellent care. Concrete practices for embedding these values in everyday clinical and management practice are discussed. Subsequent sections examine two concrete mechanisms that can help translate the

NHS organizational mission and values into a daily, operational reality for staff: the NHS Equality Delivery System and the Compassion in Practice strategy. Some other organizational practices that can support efforts to promote an equity culture, such as better data collection, commitment by the leadership, training programs, etc. are considered. In the last section, the empirical literature on the impact of market-inspired government reforms of the NHS on equity in service provision is reviewed.

3.11.1 Organizational Mission

This section articulates how the organizational mission of the NHS offers strong support for the promotion of equity in service provision. The role of the organizational mission of the NHS in creating an organizational culture that enhances equity is described in this section.

The concept of equity is at the very heart of the mission of the NHS. The guiding spirit of the NHS, the principles and values articulated in the NHS Constitution, state that the NHS has a fundamental duty, a mission, that goes beyond just providing healthcare; the NHS 'has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population'. The NHS Constitution 'sets out the enduring character of the NHS as a comprehensive and *equitable* health service' [italics mine] (The Handbook to the NHS Constitution (NHS Choices), 2015; p. 9). Thus, the aim of providing an equitable healthcare service is embedded very deeply in the NHS.

The organizational mission of the NHS is a powerful shaping force for staff who work in the NHS and, thus, is a powerful influence on the organizational culture. The Constitution, which articulates the mission, exhorts NHS staff to 'contribute towards providing fair and equitable services for all and play your part, wherever possible, in helping to reduce inequalities in experience, access or outcomes between differing groups or sections of society requiring health care' (The Handbook to the NHS Constitution (NHS Choices), 2015; p. 151). Staff are expected to be aware that the social and economic conditions into which people are born

shape their attitudes towards their health, and affect their opportunities to pursue good health and to use and benefit from health services. There is an obligation on NHS staff to appreciate that people from different socio-economic strata will vary in their perceptions of health and healthcare and have different healthcare needs and ability to benefit from care. It is, therefore, incumbent on NHS staff to ensure that patients' experiences of receiving care are not adversely affected by irrelevant considerations such as their socio-economic status, gender, ethnicity, sexual orientation, etc (The Handbook to the NHS Constitution (NHS Choices), 2015).

Some vulnerable groups of patients (such as foreign migrants, asylum seekers and refugees, Gypsy, Roma and Irish Traveller communities) experience additional barriers in accessing care such as lack of knowledge of services, illiteracy, communication issues, and prejudice and discrimination by healthcare professionals (Randhawa, 2007). These barriers deter some patients, especially, some highly vulnerable patients from accessing the services they need. The NHS Constitution, which codifies its mission, charges NHS staff to show an understanding of these issues and to take all reasonable steps to remove or reduce these barriers. The essence of equity is flexibility and adaptation of care to the needs of individuals. A standardised, inflexible, one-size-fits-all approach to care does not promote equity. The NHS mission expects staff to show initiative and adaptability to offer an equitable, individual-centric service (The NHS Constitution (NHS Choices), 2015).

3.11.1.1 Positive Obligations on Public Bodies to Advance Equality

No longer is the aim to promote equity a desirable albeit an optional goal for the NHS. When the equity-promoting aim is treated as a desirable extra rather than a core *must* by public organizations, there is a strong possibility of it being downgraded, de-prioritised and effectively ignored amidst the maelstrom of pressures faced by public bodies like the NHS. The Commission for Equality and Human Rights (henceforth, CEHR), the precursor of today's Equality and Human Rights Commission, was set up with a mission of 'mainstreaming equality and human rights' in public services (CEHR, 2004; p. 16).

The CEHR carried out a review in 2004 of the evidence on the performance of public bodies in meeting their equality and human rights obligations (CEHR, 2004). A key piece of evidence in this review was the Audit Commission's (2003) survey of public authorities. The survey indicated that the majority of public bodies surveyed had been remiss in the performance of their equality duties. 57% of the organizations had not examined their policies and practices to ensure that they were compliant with human rights legislation. Arrangements for ongoing monitoring of compliance with equality duties were completely absent in 55% of the organizations. 61% had no system of checks to ensure that their contractors were fulfilling their human rights obligations. The CEHR came to the conclusion that the statutory requirement for public bodies to 'act compatibly with human rights' was clearly not enough to compel them to take their equality duties seriously (CEHR, 2004; p. 15).

The lack of engagement by the public bodies surveyed with their human rights obligations suggested to the CEHR that reactive action by public bodies to abuses and violations of patients' human rights was an ineffective approach (CEHR, 2004). It was not enough to require public bodies to act in a non-discriminatory way and take action on cases of discrimination when they arose. It became clear to the CEHR that for the effective protection of human rights and the promotion of equality, public bodies ought to be required to proactively promote equality. Hence, a positive duty to advance equality was laid upon public bodies. The emphasis was changed from enforcement to promotion, from cure to prevention. Public bodies were, henceforth, expected to take positive measures to protect the rights of people from encroachment by others, and to assist people to enjoy their rights fully. Human rights were to be placed at the heart of public policy-making, service design and delivery (CEHR, 2004).

In reaching this decision, the CEHR took into consideration a range of evidence on the effectiveness of placing positive obligations to promote equality on public bodies (CEHR, 2004). The Commission for Racial Equality (CRE) had recently imposed a duty on all public organizations to promote racial equality, and the effects had been salutary. Research supported by the CRE to investigate the impact of these positive duties indicated that they had led to noticeable improvements in public organizations' commitment to promote racial equality. In response to the new positive duty, the vast majority of the organizations surveyed

in this research had reviewed their policies and functions with a view to harmonising them with the new duty. Most had already prepared a race equality plan or were in the process of preparing one. Staff awareness of race equality-related issues had gone up significantly. Thus, the new positive duty had had a highly visible practical impact in sensitizing decision-makers in public organizations to race equality (CEHR, 2004; p. 14-16).

The CEHR also examined evidence on the effectiveness of positive duties collated by the Equality and Diversity Forum from separate studies conducted in Northern Ireland, Scotland, Wales and Greater London (CEHR, 2004). These studies agreed on the beneficial effects of imposing a positive requirement on public organizations to promote equality. After assessing all the evidence, the CEHR summarised its opinion that 'by compelling the taking of adequately implemented procedural steps, positive duties create a climate of openness to new diversity initiatives and ensure a greater focus upon the proactive promotion of equality...experience showed that they were highly effective engines of change' (CEHR, 2004; p. 15).

The CEHR, therefore, decided to recommend the imposition of positive obligations on all public authorities to protect human rights and promote equality across all the protected characteristics (CEHR, 2004). The CEHR advised the government to create a statutory requirement for all public authorities to review their policies and operations through the prism of human rights and equality and, on the basis of this analysis, to enact plans to embed these core values in all public service policy-making and service delivery (CEHR, 2004; p. 16).

The formalisation of these positive obligations to promote equality as fundamental parts of the organizational mission of public bodies has implications for the NHS, which is perhaps one of the most iconic public bodies in the UK. These positive obligations have been given effect in the NHS through mandatory requirements such as the NHS Equality Delivery System 2 (described in more detail later) which all NHS organizations have to implement.

This section explored the central place of equity in the organizational mission of NHS providers. The next section discusses the role of organizational values in reinforcing the message of the importance of embedding equity in NHS care practices.

3.11.2 Organizational Values

It will be the aim of this section to show that the promotion of equity is an important NHS organizational value. The communication and the operationalization of this value in daily clinical and management practice is a different question though, and it will be argued later in the Discussion of Findings section that Social Enterprises perform better at articulating and incorporating organizational values in the details of day-to-day work. This section will attempt to show that, at least in theory, the aspiration to promote equity is one of the NHS's significant espoused values. The key questions that this section aims to answer are: what are the key values that NHS organizations attempt to live by, and how are these values embedded in everyday clinical practice?

NHS Values are expected to permeate and guide all the work of NHS providers. The values exist to provide a common framework and a standard for the provision of NHS services: 'Patients, public and staff have helped develop this expression of values that inspire passion in the NHS, and that should underpin everything it does. Individual organisations will develop and build upon these values, tailoring them to their local needs. The NHS values provide common ground for cooperation to achieve shared aspirations, at all levels of the NHS' (The NHS Constitution (NHS Choices), 2015; p. no. not available)

The NHS Constitution makes it clear that NHS values apply not only to the provision of services by NHS bodies but also to other organizations which are contracted to provide NHS-financed services. Moreover, the values are expected to be observed by local authorities and Public Health England in discharging their public health duties (Department of Health, 2013). This is a crucial point. It means that where Social Enterprises provide NHS-funded services, there is a clear expectation that they will abide by these values. The NHS Constitution states

that 'the values should be taken into account *when developing services with partner organisations* [italics mine], patients, the public and staff,' and that 'the principles should be embedded at every level within the health service and *among those organisations providing NHS services* [italics mine]' (The Handbook to the NHS Constitution (NHS Choices), 2015; p. 13, 15)

The significance of NHS values in laying the foundations for a culture of equity cannot be over-emphasised. As the NHS Constitution says, 'The values are integral to creating a culture where patients come first in everything the NHS does' (The Handbook to the NHS Constitution (NHS Choices), 2015; p. 13). One of the NHS values that relates to equity is that of treating all patients with 'Respect and Dignity'; the NHS Constitution states that 'this value seeks to ensure that organisations value and respect different needs, aspirations and priorities, and take them into account when designing and delivering services' (The Handbook to the NHS Constitution (NHS Choices), 2015; p. 13).

A related core value is that of 'Compassion', which encourages NHS staff to attempt to empathize with patients and carers, and to act in a humane and kind way. A third core value, which speaks directly to the principle of proportionality which is the essence of equity, is that 'Everyone counts', and that NHS staff have 'a responsibility to maximise the benefits [obtained] from NHS resources, [and] ensuring they are *distributed fairly to those most in need*' [italics mine] (The Handbook to the NHS Constitution (NHS Choices), 2015; p. 14).

One of the findings of the Francis Report into the Mid Staffordshire NHS Foundation Trust (Francis, 2013) was that some of the organizational failings that resulted in poor quality of care at the Trust were systemic and cultural in nature. The authors of the report argued that a culture of poor care was pervasive in the Trust (Rafferty et al., 2015). The report gave a clear message that the lack of a consistent culture of care and compassion can impede the spread of good practice across organisations and result in devastating experiences for patients, their loved ones and the staff caring for them (Rafferty et al., 2016; p. 3). The main thrust of the recommendations from the report was that a renewed emphasis on building a culture of compassionate care throughout the NHS was essential for preventing future abuses of

patients' human rights (Rafferty et al., 2015). The hallmarks of a culture of caring, according to Hesselink et al. (2013) and West et al. (2014), are empathy, compassion, and patient-centredness.

The *Compassion in Practice* strategy was conceived and promulgated in the wake of the revelations at the Mid-Staffs NHS Trust (Cummings and Bennett, 2012; Francis, 2013). Among organizational ethical failures in the NHS, the recent scandal involving the Mid-Staffordshire NHS Foundation Trust counts as one of the most shocking. It has become *the* defining incident of poor care in the NHS, and many wide-ranging and profoundly influential changes to the organization of care in the NHS have flowed from the discovery of the abuses that took place at the Mid-Staffs hospital. The pervasiveness of extremely poor standards of care throughout the Trust led the authors of the Francis Report to describe the failings as *systemic* and *cultural* (Francis, 2013).

The early warning signs were the unusually high mortality rates at the hospital as compared to its neighbours (Francis, 2013). This led to an inquiry during the course of which stories of appallingly poor standards of care and harrowing tales of mistreatment and suffering of patients were revealed. The completely unethical treatment of patients described in the report is summarised below (Francis, 2013).

Patients were left with excrement and in soiled bedclothes for long periods of time (Francis, 2013). Patients who could not eat without help were not given the necessary assistance for feeding. Drinking water was often not within reach. Patients who needed help in going to the toilet were not given the assistance they requested despite repeated entreaties. Water and toilet facilities were maintained in an unhygienic and clinically risky state. Untrained staff were given the heavy responsibility of performing triage in potentially life-and-death conditions on the A&E ward. Staff were uncaring and unresponsive to the concerns and anxieties of patients and their carers. Privacy and dignity, even in death, were not provided. It was a complete breach of the ethical mission and values of the NHS (Francis, 2013).

The undesirable events that transpired at Mid-Staffs led to a fresh appreciation of the importance of organizational values in NHS-provided care. The *Compassion in Practice*

strategy was implemented nationally in 2012 to embed the six core values (the 6Cs) of care, compassion, competence, communication, courage and commitment in the operations of the NHS. Six fundamental values and behaviours (6Cs) were identified as the crux of the *Compassion in Practice* strategy (Cummings and Bennett, 2012). They were:

1. *Caring* is the central purpose, the defining task of the healthcare profession. Patients have a right to expect care that is correct, appropriate and consistent.

2. *Compassionate* care means care delivered with empathy and kindness. It means giving the respect and dignity due to patients.

3. *Competence* requires caregivers to possess the necessary technical knowledge and clinical expertise to understand patients' health needs and administer the most effective and appropriate care based on the best available research evidence.

4. *Communication* includes listening effectively, and involves care staff working as a team with clinical colleagues and patients and making decisions collaboratively.

5. *Courage* demands that healthcare staff do right by their patients and challenge poor care wherever they see it. Courage also requires care staff to embrace change and constantly strive to improve care through innovation and by learning from best practice.

6. *Commitment* by all care staff to improving the health of patients, to the values mentioned earlier, and to bringing these values to their work every day. (Cummings and Bennett, 2012)

The *Compassion in Practice* strategy recommends the following actions by healthcare providers and staff working in them to put the 6C values into practice and create a culture of compassionate care (Cummings and Bennett, 2012):

a) Proactively gathering feedback from patients and carers and using it to improve the quality of care and the patient experience. Embracing patient feedback mechanisms such as the Friends and Family Test (FFT), which is now being implemented nationally in all General and dental practices, acute and emergency hospitals as well as maternity settings, and utilising the feedback thus obtained to improve services. Publishing the results of the FFT

and benchmarking performance against comparable provider organizations, public and private.

b) Healthcare providers collaborating with patient participation groups to discuss the published data from the Friends and Family Test and, through this process, identifying areas of concern and prioritising action steps to address them.

c) Commissioners and providers actively disseminating examples of good practice that can be transferred and reproduced in other settings.

d) Management focusing on improving staff experience, which has knock-on effects for patient experience. Creating a healthy and safe working environment and a rewarding and worthwhile care-giving experience for staff. Extending consideration, kindness, compassion and care not only to patients but also to staff. Appreciating the close relationship between the treatment of staff and the patient experience. Nurturing and supporting staff to perform their care-giving roles with excellence. Equipping them with the necessary skills and competences and providing them adequate resources to do their jobs well.

e) Developing the leadership abilities of nurses, midwives and managers and supporting them to provide leadership within their teams in building a culture of high quality and compassionate care.

f) Early career development and opportunities for leadership roles for junior care staff. Development of a bespoke leadership programme by the NHS Leadership Academy for nursing directors and ward managers specifically tailored to the implementation of the 6C values and behaviours.

g) Values-based recruitment and socialization of new employees. Ensuring that values are taken into account along with academic and technical abilities in the admission of students to educational and training courses for careers in the caring professions. The vital necessity of including the values of compassion and caring in the assessment, recruitment, education, and training of medical professionals was strongly emphasized by the Francis Report (Francis, 2013).

h) Building the desired values and behaviours (6Cs) into the performance appraisal process for all employees. Alignment of incentives with the values and behaviours. Evaluating how well staff demonstrate the desired values and behaviours, and rewarding individuals, teams and organizations which excel in practising the 6Cs in their care-giving work.

i) Better use of technology to support staff in living the values and practising the desired behaviours.

j) Partnership between Health Education England, the medical education sector, NHS provider organizations, and care quality regulators to integrate the 6C values with education and training for prospective and current healthcare staff.

k) Programme of skill development for care staff around dignity and respect for patients. Incorporating the recommendations of the Dignity Code, the National Pensioners Convention and the Dignity in Care campaign's Dignity challenge. Drawing up training plans and instituting organizational systems designed to create a culture of dignity and respect for patients.

l) Making the 6Cs integral to strategy-planning and policy-development.

m) Mainstreaming the regular use of the Culture of Care Barometer to assess and change organizational cultures towards more caring and compassionate cultures.

n) Strengthening accountability and early warning mechanisms such as the Nursing and Midwifery Council's Raising Concerns process. (Cummings and Bennett, 2012). The Francis Report emphasized the need to hold care-givers, both individuals and organisations, sufficiently accountable for their actions (Francis, 2013). The report laid strong emphasis on compliance with NHS values and ethics being an essential requirement for senior leaders and managers in NHS Trusts, and for serious non-compliance with the values being grounds for questioning their fitness to lead the organization (Francis, 2013).

This section discussed the importance of organizational values in the NHS and ways of incorporating them into everyday clinical and management practice so as to make them an

integral feature of the way care is delivered in the NHS. The next section explains how an NHS organization's mission and values can be translated into practice.

3.11.3 Performance Management Systems

3.11.3.1 The Importance of Alignment

Clarifying and articulating an organization's mission and values is only the first step in making them an organizational reality. Breathing life into an organization's mission and values involves the much more arduous process of aligning the organization on a daily basis with the mission and values. Alignment is where the rubber meets the road**.** There has been a steadily growing recognition among NHS policy-makers that the principles and values set out in the NHS Constitution need to be *woven into* the *warp and woof of the way NHS operates.* The importance of alignment, of putting the NHS principles and values into consistent practice, is underlined in the NHS Constitution: 'For the Constitution to succeed in its aims, it needs to become part of everyday life in the NHS for patients, the public and staff. Achieving this requires leadership, partnership and sustained commitment over months and years from all those involved in the provision of NHS services, to raise awareness of the Constitution and weave it into the way the NHS works at all levels (The Handbook to the NHS Constitution (NHS Choices), 2015; p. 5)

One way in which an organization's operational practices can be brought into alignment with its mission and values is through the use of catalytic mechanisms (Collins and Porras, 1994; Collins, 1999). A catalytic mechanism is a driver of change. It creates clear accountability to ensure that what is said is done.

Performance management systems are one type of catalytic mechanism that is commonly used by organizations to ensure the accomplishment of organizational objectives. A good

example of the effective use of performance management systems as catalytic mechanisms comes from The 3M Corporation (a private American company greatly admired for its long history of creating a wide range of innovative products, such as waterproof sandpaper, cellophane 'Scotch Tape' and Post-it Notes). For 3M, innovation is a core organizational value. To make this value a fundamental part of the organizational fabric, 3M has instituted several powerful catalytic mechanisms to stimulate creativity and innovation (Collins and Porras, 1994). One notable example is that the 3M Corporation demands of itself that it earn 60% of its revenues from new products created in the last 5 years. Management rigorously enforce this requirement. The consistent implementation of the rule of deriving the majority of their revenues from new products forces the organization to constantly innovate. Another catalytic mechanism used by 3M is allowing employees to spend 10-15% of their work time on projects of their own choosing, a practice that has been copied by highly innovative and successful software companies such as Google (Collins and Porras, 1994; Collins, 1999).

It is worth noting, however, that a mechanism can catalyse action only if it is rigorously enforced, i.e., only if it has teeth (Collins and Porras, 1994; Collins, 1999). Without rigorous enforcement - without teeth - a mechanism loses its effectiveness. It becomes a tokenistic, perfunctory tick box exercise. Further, a mechanism can be a radical force for change but only if it is applied with discipline and consistency. If it is applied inconsistently, it loses much of its force (Collins and Porras, 1994; Collins, 1999).

In relation to patients' human rights and equality legislation, Pollock (2015) argues that human rights can be a catalytic mechanism for promoting equity but they need to be enshrined in law for them to have teeth: 'Everything follows and flows from the law; our morality and values have to be enshrined in the law if universal healthcare is to be a reality' (p. 400). Being enshrined in law, being mandatory and rigorous monitoring for compliance are three ways of giving the human rights mechanism teeth.

The Francis Report took a clear view that the core values of the NHS, as expressed in the NHS Constitution, are rendered ineffective if there is no obligation or necessity for staff to abide by them (Francis, 2013). The values, the report argued, ought to be backed up by the

force of the law. The report advocated the inclusion of NHS values and the chief principles of the NHS Constitution in employment contracts to underline a formal commitment by NHS staff to uphold these principles and values.

The Francis Report (Francis, 2013) recognised the crucial role played by performance appraisal systems in upholding ethical and professional standards and advised that active use be made of performance management processes for monitoring and enforcing a culture of compassion and caring. The report stated that one of the reasons for the breakdown of care at Mid-Staffs was inadequate monitoring of performance and abdication of, or shifting to others of, the responsibility for intervention in cases where poor performance was identified (in short, lax monitoring of performance and buck-passing).

The Francis Report (Francis, 2013) recommended that an annual review of every clinician's commitment to NHS values be made a part of the performance management process. Clinicians would be required to provide evidence of demonstrating compassion and care towards patients, carers, and co-workers. A 360-degree appraisal process consisting of feedback from patients and their families as well as professional colleagues was recommended by the Francis Report. This feedback would be made available to the appropriate professional regulatory and accreditation bodies (such as the General Medical Council) and would be used to revalidate the clinician's registration and confirm their fitness to practise (Francis, 2013).

Health Equity Audits (HEAs) are another potential catalytic mechanism for promoting equity in public healthcare organizations (Flowers and Pencheon, 2002; Hamer et al., 2006). HEAs were introduced in the NHS in 2003. At their inception, they were mandatory for all NHS providers. Their mandatoriness made them a potentially radical force for change. Shortly after this requirement was introduced, a slew of equity analyses was produced by various NHS Trusts. Equity-consciousness seemed to be growing among NHS providers. There was hope that measuring and improving equity performance would become the way of life in the NHS.

However, these hopes were quickly disappointed. When the Conservative-Liberal Democrat coalition government came into power in 2010, it made HEAs optional. The optionality robbed the HEAs of their teeth, and the momentum generated by the previous initiative was lost. When the successor to the HEAs, the NHS Equality Delivery System (EDS) was introduced, it, too, was optional and, therefore, largely ineffective. The mechanism's potential was under-utilised. The revised version of the NHS Equality Delivery System, EDS2, was made mandatory for all NHS providers in March, 2015 (NHS England, 2015). Now that it has been made mandatory, it is likely to prove more effective in galvanizing efforts by NHS organizations to demonstrate tangible improvements in the equity of their services.

If a healthcare provider organization claims that one of its core aims is to promote equality but does not support this aim by tracking how well it is meeting this objective, one could question its sincerity. The absence of alignment between the stated organizational aim of promoting equality and day-to-day operational practice calls into question the depth of the organization's commitment to its goal of promoting equality. To address the gap between the NHS's claim to be an equity-promoting organization and the actual practice which fell well short of those standards time and again, measures have been taken by UK governments in recent years to institute catalytic mechanisms to drive a cultural change. Two prominent examples are the NHS Equality Delivery System 2 and the *Compassion in Practice* Strategy. These are discussed in more detail in the following sections.

3.11.3.2 Catalytic Mechanisms 1: NHS Equality Delivery System

In recognition of the vital role that the NHS could play in promoting equity, fairness and social justice, new legal frameworks have been created to strengthen the equity-promoting function of the NHS. Two specific pieces of legislation are especially relevant in this context: a) The Public Sector Equality Duty, stemming from The Equality Act 2010, and b) The Health and Social Care Act 2012 which places legal duties on the Secretary of State for Health, NHS England, Clinical Commissioning Groups and Monitor 'to have regard to the need to reduce inequalities in access to, and outcomes from, health care services for patients,

and to assess and report on how well they have fulfilled this duty' (The Handbook to the NHS Constitution (NHS Choices), 2015; p. 15, 23).

The Public Sector Equality Duty (PSED) places obligations on NHS organizations to take action to 'eliminate discrimination, harassment and victimisation; advance equality of opportunity; and foster good relations' (NHS England, 2013; p. 12). Specifically, the PSED states that NHS providers have to set equality objectives for their services at least once every 4 years and make their objectives public. Further, the PSED requires an annual report by NHS providers to show progress towards meeting their equity objectives (NHS England, 2013; p. 12).

A catalytic mechanism to promote equity that flowed from the PSED and the Health and Social Care Act 2012 is the NHS Equality Delivery System 2 (NHS England, 2013). EDS 2 consists of 18 outcomes which are grouped into 4 goals ('Better Health Outcomes', 'Improved Patient Access and Experience', 'A Representative and Supported Workforce', and 'Inclusive Leadership') years (NHS England, 2013; p. 7-8). These 18 outcomes define the criteria for a fair and equitable service for patients and the fair treatment of the workforce. These criteria have been chosen through consultations with patients and staff and represent issues of the greatest salience for these two groups. NHS organizations are expected to assess their performance on equality-promotion along these 18 dimensions in consultation with patients, staff and other local stakeholders. Based on this evaluation, NHS Trusts are expected to identify the areas most in need of improvement and set equality objectives for the next 4 to 5 years (NHS England, 2015; p. 6). When evidence is found of poor performance in meeting equality objectives, NHS organizations are expected to take actions to secure improvements (NHS England, 2013; p. 16).

The 18 outcomes used in EDS 2 are aligned with the requirements of the NHS Constitution, the Care Quality Commission's key inspection questions, and the NHS Quality and Outcomes Framework. Thus, there is an incentive for NHS organizations to meet their EDS 2 goals as they would simultaneously be meeting their business objectives (NHS England, 2013).

To assist the measurement and tracking of progress in improving the equity of services, EDS 2 recommends that NHS providers make public their equality objectives, improvement plans,

and the progress they have made in achieving their objectives (NHS England, 2013). NHS bodies are encouraged to make this information accessible and publish it on their websites, in annual reports and in other formats. Trusts are advised to share this information with local Health and Wellbeing boards, NHS commissioners, the Care Quality Commission (CQC), NHS England Area Teams and other local stakeholders and, thereby, initiate a discussion with these bodies around areas for improvement. The purpose of this sharing of information with local partners is to promote transparency, openness, accountability and rapid action in areas where a need for development is identified (NHS England, 2013; p. 15).

EDS 2 cautions NHS organizations against the risks of self-assessment (NHS England, 2013). When organizations attempt to grade themselves on how well they are performing against the requirements of EDS 2, biases and inaccuracies may result. To aid objective assessment and accountability, NHS organizations are encouraged to include external, independent local stakeholders in the process of grading their performance. These stakeholders could be local Healthwatch organizations, or voluntary sector organizations. NHS organizations could also benchmark their performance against that of comparable neighbouring NHS Trusts in a form of peer review (NHS England, 2013; p. 17).

EDS 2 recognises that the promotion of equity is a responsibility of both commissioners and providers of NHS services, and that commissioners have a vital role to play in the promotion of equity (NHS England, 2013). By making EDS 2 a requirement for both commissioners (CCGs) and providers (NHS Trusts), EDS 2 facilitates the integration of an equity consciousness into both commissioning processes and service delivery so that changes needed to support equity can be made in a systematic and comprehensive way by both the key players (NHS England, 2015).

Under EDS 2, Clinical Commissioning Groups (CCGs) can ask private providers to which they contract the delivery of NHS-funded healthcare services to apply EDS 2 (NHS England, 2013; p. 5).

The implementation of EDS 2 is the responsibility of the leadership of NHS organizations. The senior management of the organization has to demonstrate compliance with the legal duties laid down by the Equality Act 2010 (NHS England, 2015; p. 8).

EDS 2 expects the senior management of NHS bodies to provide leadership in the promotion of equity to the rest of the organization. EDS 2 requires that 'Boards and senior leaders *routinely* [italics mine] demonstrate their commitment to promoting equality within and beyond their organisations' (NHS England, 2013; p. 8). For instance, Board decisions have to show evidence of having considered the risks to equity arising from organizational changes; plans for managing these risks have to be shown. Risk assessments need to reflect understanding of the requirements of the Public Sector Equality Duty (NHS England, 2013).

Another way in which the organization's senior leadership is expected to show its commitment to equity is through the allocation of resources and through support for specific equity-promoting schemes for patients and staff (NHS England, 2013). Board members are encouraged to attend Board Leadership programmes with a specific focus on fostering inclusive services and workforces. Middle management and line managers are given the responsibility of training their staff to be sensitive to the different cultural requirements of their patients and to ensure that staff or patients do not experience discrimination (NHS England, 2013; p. 8, 33-34).

EDS 2 has the potential to effect real change as it pushes leaders to go beyond paying lip service and demonstrate a strong, sustained drive to advance equality of opportunity (NHS England, 2013). Leaders are expected to articulate a vision backed up by a concrete plan to realise the principles and values in the NHS Constitution. They are given the responsibility of creating a service that enables all patients to access and benefit from services equitably. They are charged with a duty to create a fair and meritocratic work environment where staff are judged only on the basis of their performance, and are not treated differently on the basis of irrelevant factors such as their socio-economic status, gender, ethnicity, sexual orientation, etc. (NHS England, 2013).

To facilitate the realisation of this vision, EDS 2 guidance recommends that equalities governance be integrated with mainstream governance so that equality planning and business planning can be joined up and, thereby, rendered more effective (NHS England, 2013). EDS 2 recognizes that progress in advancing equality is best made when departments and individuals work together, and not in silos. EDS 2 also encourages leaders to communicate to

staff that everyone's role touches on equity in some way, therefore, promoting equity is everyone's responsibility (NHS England, 2013; p. 14).

When EDS 1, the predecessor of the EDS 2 was introduced, it was optional for NHS providers. However, in the March, 2015 refresh, EDS 2 was mandated for all NHS providers (NHS England, 2015). The optional character of EDS 1 increased the risk that amidst the immense pressures and multiple challenges confronting NHS Trusts, the equity agenda might slip off their radar. The mandatory nature of EDS 2 reduces that risk and makes it a much more effective and potential engine of change. It ensures that despite the major upheavals in the NHS, provider organizations do not lose sight of one of the NHS's core values (NHS England, 2013; p. 36).

The NHS has been going through a period of radical and far-reaching change. Organizational changes that do not aim at fair treatment of patients and staff could prove harmful. EDS 2 ensures that the implications of the changes in the NHS for patients and staff are fully thought through and that the gains and downsides of the changes are equitably distributed (NHS England, 2013). EDS 2 brings considerations of fairness and equity to the forefront of the analysis and decision-making preceding organizational change. As the NHS adjusts to the necessity of operating with fewer resources and staff, EDS 2 supports the preservation of the character of the NHS as a fair, equitable healthcare system, and one in which the principle of fair treatment of patients and staff is at the heart of decision-making (NHS England, 2015; p. 2).

3.11.3.3 Catalytic Mechanisms 2: The *Compassion in Practice* Strategy

Another catalytic mechanism currently being introduced into the NHS to achieve consistent implementation of the NHS organizational mission and values is the *Compassion in Practice* strategy (Cummings and Bennett, 2012). Earlier in this section, several ways in which the values of caring and compassion can be embedded in an organization's culture were suggested. One particularly important way is through the use of the Culture of Care Barometer (Rafferty et al., 2015; 2016). This is discussed in more detail below.

The Culture of Care Barometer is a short staff survey that assists staff in gauging whether the culture in the team, department or the organization supports the delivery of compassionate, patient-centric care (Rafferty et al., 2015; 2016). The Barometer serves a diagnostic function and as an aid to stimulate reflection on existing practice and ways of improving the culture of care. It can be employed as a 'dip-stick' to assess the culture in different parts of the Trust at one point of time, thereby, offering a snapshot of the organization's culture of care at a particular moment (Rafferty et al., 2015; p. 13, 59). It can also be used to compare the organization's culture at different points of time, thereby, making possible an assessment of whether the culture of care is improving or getting worse. Since it permits comparison of changes in the culture of care over time, the tool can act as an 'index of change' and offer a ready measure of the impact of service re-configurations on patient care (Rafferty et al., 2015; p. 13, 59).

In the pilots of the Barometer carried out so far, staff reported finding it a stimulating tool which enabled them to reflect on and to engage in focused discussions about specific areas of the culture of care that needed improvement (Rafferty et al., 2015). The Barometer acted as an early warning system, helping staff to spot areas that needed urgent attention. The main utility of the Barometer lay in its ability to point out problematic parts of the culture of care and bring them to the fore in discussions. Encouraged by the belief that 'culture changes by talking about it,' staff participated enthusiastically in discussions around issues uncovered by the Barometer (Rafferty et al., 2015; p. 59).

The discussions sparked by the Barometer were the beginning of a dialogue between management and clinical staff and resulted in the formulation of action plans to address the developmental needs that were identified. The Barometer, thus, played a vital role in motivating staff to think about their responsibility for creating a positive culture of care in the organization (Rafferty et al., 2015).

The Trusts that piloted the Culture of Care Barometer supported its implementation with a robust plan to motivate staff to engage with the tool (Rafferty et al., 2015). A range of media were employed to disseminate information about the Barometer and to encourage its take-up. Blog entries, discussions at executive meetings and Trust conferences, and emails were some of the methods used to include the widest range of staff possible. The Barometer was integrated with other culture-related initiatives such as 'culture transformation projects' going

on at the same time at the Trusts to give it greater publicity and to encourage its adoption by staff (Rafferty et al., 2015; p. 59).

The Francis Report had recommended that the task of fostering a culture of caring applied to all healthcare staff (including doctors and the management). In its initial application at least, the *Compassion in Practice* strategy was directed primarily at nurses, midwives and healthcare assistants (Rafferty et al., 2015; p. 4). The creation of a culture of compassionate care (and the use of the Barometer) was, somewhat problematically, viewed as the exclusive responsibility of the nursing staff. Policy documents reflected this confusion. For example, the 6Cs were described as 'a set of values that underpin Compassion in practice, a vision and strategy for nursing, midwifery and care staff - in fact all health and care staff' (NHS Health Education England, 2014; p. no. not available) A narrow application of the *Compassion in Practice* strategy to nurses and some other specific staff groups was deemed to reduce its effectiveness (Rafferty et al., 2015).

Subsequently, attempts were made to widen the audience for the 6Cs and to include all healthcare staff under its purview. This followed the understanding that compassion was central and essential to all care, and that the implementation of the six core values was not limited to the domain of nursing. Their universal applicability at every step of the care process was acknowledged (Beal, 2014). There was an increasing recognition that all staff, clinical and non-clinical, from receptionists to porters to doctors to physiotherapists to managers to executive Boards and commissioning Boards were involved in, and had an influence on, the process of caring (NHS England, 2014).

It was also agreed that patients had a right to expect consistent treatment throughout the care pathway, and that different, often multidisciplinary, teams from different organizations caring for patients at various stages of the care journey would work better together if they shared key values (Beal, 2014). Therefore, determined efforts were made to extend the reach of the 6Cs to the entire spectrum of healthcare professionals and provider organizations. The charity sector, including hospices and care homes, was also encouraged to adopt the core values so as to offer continuity and consistency in care (Beal, 2014).

This section described the use of performance management systems as catalytic mechanisms to achieve alignment between organizational mission and values and everyday operational

practice. Two specific mechanisms, the NHS Equality Delivery System 2 and the *Compassion in Practice* Strategy were explained in detail. The next section provides an overview of some other organizational practices that can contribute to strengthening the ethical and equity culture of NHS organization.

3.11.4 Other Organizational Requirements for an Ethical (and Equitable) Organizational Culture in the NHS

This section draws upon other research on ethical culture in public providers to identify organizational practices that can assist in reinforcing a culture of ethical and equitable behaviour in NHS provider organizations.

A research report by the Equality and Human Rights Commission on the performance of public bodies of their duties in relation to transsexual and transgender people (Rankin et al., 2010) identified some of the requirements for building an organizational culture that promoted equitable care for transgender individuals. Even though this report dealt with issues specific to transgender individuals, the findings and recommendations could easily be generalised more widely to other groups with protected characteristics under the Equality Act.

The report criticized public sector organizations which took the first step of including transgender individuals in their equality plans but did not follow this up with specific, actual actions that could demonstrably improve transgender equality outcomes. Noble intentions and hollow rhetoric, Rankin et al. (2010; p. 11) argued, were no substitute for concrete actions.

The implication for NHS organizations is that preparing equality plans is a valuable first step, however, robust execution of the plans and demonstration of tangible and meaningful improvements in equality outcomes over time is imperative. Too often, NHS equality plans remain on paper, and potential improvement is not translated into actual performance. Hence, the requirement to demonstrate year-on-year improvement placed on NHS bodies by mechanisms such as the NHS EDS2 is likely to be an effective catalyst of action.

The report listed some of the challenges to public bodies in meeting their obligations under the Equality Act to transgender service users. Rankin et al. (2010) claimed that a lack of baseline data, particularly, data at a local (city or borough) level, and weak monitoring of progress towards meeting equality objectives hindered efforts to promote equity and pointed to the need for improvements in data collection. They pointed to the challenges of demonstrating compliance with the legal duties in the absence of reliable data on outcomes and progress monitoring (Rankin et al., 2010; p. 11, 51-54).

The key insight from this for NHS Trusts is that a systematic data collection effort is needed to underpin consistent efforts to promote equity. Many NHS Trusts do not collect data on the relevant equity dimensions (gender, ethnicity, religion, sexual orientation, etc.) to carry out meaningful analysis of disparities in the experiences of their service users (source). In many instances, national data is used as a proxy for local data without taking into account local differences in the composition and demographic characteristics of the population (source).

A visible, sincere and consistent commitment to transgender equality by the leadership in the public organization and by the Equality and Human Rights Commission were emphasized as key drivers for pro-equity change (Rankin et al., 2010). The Commission, Rankin et al. (2010; p. 11-14) suggested, could stimulate positive change by providing public bodies practical, accessible guidance on their legal duties and advice on ways of engaging with the transgender community. A King's Fund Survey of NHS Staff (The King's Fund, 2014) also arrived at a similar finding. Staff who took the survey were emphatic in their view that the actions of the leadership of the organization are the most important influence on the ethical culture of an organization.

The lesson that NHS bodies could usefully derive from this is that the senior management has a critical role to play in fostering a culture of equity in the organization. Without a clear and visible commitment to equity from the senior leadership, efforts to mainstream an equity focus are unlikely to succeed. At the same time, commissioners of NHS services, too, have a vital function to perform. Commissioners can hold providers to account for meeting their equality duties. Commissioners can assist providers by identifying the equity needs of the local population and ensuring that providers are mindful of the need to address these issues and to demonstrate progress in promoting equity.

Another factor that was identified as having significant potential for improving equity for transgender users was staff training (Rankin et al., 2010; p. 61-62). The erstwhile NHS Wolverhampton Primary Care Trust (PCT) initiated a comprehensive Equality and Diversity training programme for its employees over a period of 18 months (Rankin et al., 2010; p. 55-57). Two-thirds of the staff underwent training in how to treat transgender service users fairly and how to create safe spaces for them. Designed and delivered with input from members of the LGBT user group, the programme resulted in the majority of staff being sensitised to transgender issues and a reduction in the number of complaints from transgender service users. Another welcome effect of the training was the professional development of the transgender service users who contributed to the programme. Participation in this programme boosted their confidence and increased their skills; some of them subsequently went on to speak on transgender equality issues at national conferences (Rankin et al., 2010; p. 55-57).

Another public organization, the Wrexham County Borough Council in Wales, offered short Transgender Awareness sessions (called 'Lunch and Learn') twice a year for its staff as well as more detailed training courses on request to departments (Rankin et al., 2010; p. 55-57). A wide range of staff (housing officers, social workers, administrators, etc.) benefited from the training. The training reduced their discomfort and increased their competence in serving transgender users who reported greater satisfaction and trust that their needs would be met by local government staff as well as an increased likelihood of accessing the services offered by the Council.

The transferable insight for NHS staff from these examples is that comprehensive, ongoing training and education on equity issues is a central plank of a strategy to promote equity. In many NHS organizations, training on equity issues tends to remain confined to the mandatory annual Equality and Diversity training. NHS organizations ought to consider expanding or supplementing the mandatory training with modules focused on the various dimensions of equity (socio-economic status, religion / faith, gender, ethnicity, sexual orientation, etc.).

The availability of an expert on equity issues was cited as a vital contributory factor in facilitating a culture of equity (Rankin et al., 2010; p. 62-63). Healthcare staff might be daunted by the complexity of equality legislation, overwhelmed by the sheer number of equity issues specific to various vulnerable groups, and unsure of how to meet their public

duties. Having an expert to turn to for guidance in times of doubt or confusion was reported to be a valuable support to the equity-promoting efforts of staff. In addition to the provision of expert advice, the assignment of responsibility to an individual for leading on equity issues was proposed as a key lever in creating a culture of equity. While equity was a part of everyone's role, the need for a clear leader who would be ultimately responsible and accountable for spearheading the equity efforts of the organization was recommended (Rankin et al., 2010; p. 62-63). The insight from this for Social Enterprises is to have a dedicated individual who leads on equity and to ensure that all staff are aware of who this individual is.

Lack of adequate resources (staff time or budget) was reported as a significant contributory factor in staff not being able to meet their equality duties (Rankin et al., 2010; p. 63). This was also the finding of the King's Fund Survey of NHS Staff (The King's Fund, 2014). 32% of the surveyed staff said that lack of time and resources was the biggest barrier to providing compassionate care to patients. These results indicate the importance of leadership in both NHS and SE organizations ensuring that sufficient resources are provided for staff to perform their equity-related tasks.

This section described some additional organizational levers that NHS and SE providers can use to encourage their staff to behave more ethically and equitably. The importance of translating equality plans into concrete action steps and of rigorously monitoring action plans was described. The necessity of robust data collection and analysis systems to support efforts to promote equity was articulated. The pivotal role played by the leadership of the organization in shaping its ethical and equity culture was highlighted. The use of training programs and socialization to influence staff's attitudes and behaviours in an ethical direction was suggested. The presence of an expert on ethics and equity to whom staff can turn for guidance in times of doubt and uncertainty was emphasized. Finally, the vital requirement of adequate resources (time, money, equipment) to support staff's equity-promoting efforts was indicated. In the next section, the empirical literature on the impact of market-driven reforms on equity in the provision of public healthcare services is reviewed.

3.12. Summary of Empirical Studies on the Impact of Market-inspired Reforms of Public Healthcare Services on Equity in Service Provision

The impact of market-inspired reforms on equity in the provision of publicly-financed healthcare services is a subject that has given rise to a lot of dispute. Empirical studies comparing privatised (or marketised) and public provision of healthcare services are divided on the subject and inconclusive. In this section, the empirical literature on this subject is reviewed. Some studies have claimed that private provision increases inequities in provision (Whitehead, 1994; Dusheiko et al., 2004; Cookson and Laudicella, 2011; Mindell et al., 2008; Kirkwood and Pollock, 2016). Other studies have argued that private provision has a non-negative or positive impact on equity (Laudicella et al., 2009; Cookson et al., 2010, 2012, 2013; Cooper et al., 2009). Some of these studies are briefly reviewed below. The studies that have found negative effects on equity from marketisation are grouped together and presented first, followed by a group of studies that have found non-negative or beneficial impacts for equity from marketisation.

3.12.1 Adverse Effects on Equity from Market-inspired Reforms

One of the earliest steps in the direction of market-inspired reforms was the introduction of the practice of GP fund-holding in 1990-91 (Brereton and Vasoodaven, 2010). Under this policy, General Practices (GPs) were offered the role of purchasers of health services. GPs were given the option of receiving funding and becoming *fundholders* for their patients. Whitehead's (1994) review suggested that GP fundholding might have increased inequities in access to primary care. She observed that GP fundholding had begun to create a two-tier system in which patients whose GPs were fundholders had better access to certain purchased services (for example, physiotherapy, health visiting, community mental services) than the patients of non-fundholding GPs. Whitehead argued that a second way in which GP fundholding may have increased inequities in patient care was through hospitals selecting patients of fund-holding GPs from waiting lists ahead of those from non-fundholding GPs.

Dusheiko et al.'s (2004) study supported Whitehead's observations about the practice of fund-holding leading to more inequalities in access to care. Their study compared waiting

times for elective surgery between fundholding and non-fundholding GPs. The researchers found that the waiting times for patients from fundholding GPs were shorter by 5% to 8% than those for patients of non-fundholding GPs. Dusheiko et al. argued that holding a budget enabled some GPs to negotiate shorter waiting times for their patients, resulting in a disadvantage for patients of non-fundholding GPs.

In the early 2000s, the Tony Blair and Gordon Brown governments introduced further market-oriented healthcare reforms (Cookson and Laudicella, 2011). Under these reforms, NHS hospitals were offered attractive incentives to shorten waiting times and length of stay for elective surgery. Critics of these reforms warned that they would harm socio-economic equity by encouraging hospitals to discriminate against poorer patients who tend to stay longer and cost more to treat (Cookson and Laudicella, 2011).

Cookson and Laudicella (2011) investigated whether the new inducements offered to hospitals were tempting them to select against poorer patients. They focused on one elective surgery – hip replacement – and examined the effects of the reforms on equity in the utilization of hip replacement surgeries. Their analysis suggested that hip replacement surgeries for the poor do not cost much more, therefore, the poor are not likely to be disadvantaged by the new incentives to hospitals. However, the same surgeries for the elderly and the very sick do cost significantly more, putting them at a greater risk of being disfavoured by the new incentive regime. Cookson and Laudicella (2011) concluded that socio-economic equity was less likely to be reduced by the new efficiency incentives. However, equity for the elderly and those with chronic and multiple conditions might be adversely affected.

Mindell et al., 2008 examined the impact of encouraging private provision of care on equity in the geographical distribution of healthcare facilities. Access to care is an important determinant of health equity. Mindell et al. (2008) began with the acknowledgment that there were already geographical variations and inequalities in the provision of certain types of NHS care. Their investigation focused on whether the addition of privately funded care helped address these inequalities by complementing NHS provision and closing the gap in areas

where provision was poor, or whether it worsened these regional inequalities by over-supplying care in areas where NHS provision was already good.

Mindell et al. (2008) analysed the distribution of NHS-funded and privately funded care for coronary revascularisation in London between 2001 and 2003. Their study found that the use of privately funded care was highest in areas of lowest need, and that the addition of privately funded care tended to make the distribution of care significantly less equal than NHS-funded care alone. The researchers concluded that privately funded care exacerbated existing regional inequalities in the provision of NHS-funded care.

A study of NHS-funded elective primary hip arthroplasties in Scotland between 2008 and 2009 arrived at similar findings. Kirkwood and Pollock (2016) found that the UK government's policy of encouraging patient choice and private provision of NHS-funded care had resulted in a reduction in public provision and had increased inequalities in access to care. The researchers concluded that as a result of the increased use by NHS Commissioning Boards of private provision of NHS-funded care, NHS provision had declined and that age-related and socio-economic inequalities in access to care had increased.

3.12.2 Non-negative or Beneficial Impacts for Equity from Market-inspired Reforms

Studies by other researchers were more positive about the impact of market-driven reforms on equity. A study by The King's Fund (Brereton and Vasoodaven, 2010) suggested that the practice of fund-holding may have increased equity in access to primary care. The study observed that in fundholding GPs, 5% of patients consumed 68% of the fundholding GPs' budgeted expenditure. The researchers inferred from this extremely imbalanced pattern of expenditure that fundholding GPs were actually promoting equity by spending significantly more money on patients with greater needs.

Duckworth et al. (1992) concluded from their observations of the practice of GP fundholding that it gave GPs the financial flexibility to prioritise the population sub-groups which were most in need of additional services (for example, to better serve the greater needs of poorer patients), thus, increasing equity. In a similar vein, Laudicella et al. (2009) analysed the effect of GP fundholding on equity in the utilization of secondary care for elective hip replacements across England. Their analysis indicated that the practice of GP fundholding did not necessarily reduce equity in access to hospital care.

Between 1991 and 2001, new reforms were phased in to strengthen the internal market in the English NHS. These market-oriented reforms included the encouragement of competition between NHS Hospital Trusts. Cookson et al. (2010) investigated the effects of these reforms on socio-economic equity in the utilization of care for hip replacement and heart revascularization between 1991 and 2001. Their analysis showed that greater competition between NHS Hospital Trusts did not lead to an increase in socio-economic inequity in access to hip replacement or heart revascularization surgeries. Their study could neither find a reduction in socio-economic equity after the introduction of competition nor an increase in equity after the removal of competition. Cookson et al. (2010) concluded that a small amount of internal market competition (such as had been introduced by UK governments between 1991 and 2001) was unlikely to have had a significant and pervasive impact on socio-economic healthcare equity.

Cookson et al. (2013) extended their earlier study (Cookson et al., 2010; mentioned above), focusing this time on the impact of market-inspired policy developments on equity over the period 2003 to 2008. In the early 2000s, policy-makers promoted even more competition between NHS hospitals as a lever to drive up care quality standards (Cookson et al., 2013). Cookson et al. (2013)'s study aimed to assess whether the acceleration of competition between NHS hospitals had produced an adverse impact on equity in access to secondary healthcare. Their analysis indicated that increased hospital competition under fixed prices between 2003 and 2008 had not reduced socio-economic equity in the utilisation of secondary care. On the contrary, increased competition had actually led to a very slight increase in socio-economic equity, due to a slightly faster rise in elective inpatient admissions in deprived areas.

The period 2001-2008 was a time of significant change for the English NHS. During this period, the NHS experienced a number of reforms inspired by private sector management thinking. These powerful changes included target-driven reduction in hospital waiting times (from 2001), a pay-for-performance scheme in primary care (introduced in 2004), and increased hospital choice and competition (that took effect from 2006) (Cookson et al., 2012). Indeed, the scale and potency of these reforms led some observers to warn that the naked encouragement of choice and competition and the expansion of private sector provision might have a negative impact on equity (Appleby, Harrison, & Devlin, 2003; Barr, Fenton, & Blane, 2008; Oliver & Evans, 2005).

Cookson et al. (2012) examined a wide range of services (non-emergency outpatient and inpatient hospital care for hip replacement, senile cataract, gastroscopy and coronary revascularisation) over the period 2001 - 2008. As before, their aim was to assess the impact of NHS reforms over this period on socio-economic equity in access to specialist care in the English NHS. Cookson et al. (2012)'s analysis found no adverse impact on socio-economic equity in access to specialist care resulting from the package of market-based reforms introduced between 2001 and 2008. On the contrary, the slightly faster increase in utilization of non-emergency inpatient care in deprived areas suggested that equity had improved very slightly.

The three empirical studies conducted by Cookson and colleagues (Cookson et al., 2010, 2012, 2013) all came to similar conclusions – that the anticipated adverse effects on equity of market-inspired reforms had not materialised. If anything, equity had improved very slightly.

A conceptually similar study with similar results was conducted by Cooper et al. (2009). The researchers examined changes in waiting times for a set of key elective procedures (knee replacement, hip replacement, and cataract repair) in the English NHS between 1997 and 2007. Cooper et al. (2009) found that patients in the most deprived areas had experienced the greatest reductions in waiting times. Their analysis suggested that the market-oriented

reforms over the period examined in the study had not harmed equity and may have even increased equity.

In this section, the empirical literature dealing with the impact of market-inspired government reforms on equity in public healthcare provision was reviewed. The overall picture is one of mixed findings, with some studies arguing that marketisation has reduced equity in care, and others suggesting that the anticipated risks to equity from marketisation have not materialised so far.

3.13 Conclusion

This section began by discussing the key role of organizational mission in creating an ethical and equitable culture in NHS organizations. Following next was an examination of NHS organizational values and their central importance in building a culture of caring, compassion, empathy and equity in the NHS. Later sections looked at two concrete mechanisms that can be used to operationalize and embed the NHS organizational mission and values in everyday work: the NHS Equality Delivery System and the Compassion in Practice strategy. Other organizational systems that can facilitate the creation of an equity culture in the NHS - better data collection, commitment by the leadership, training programs, etc. - were discussed. In the last section, the empirical literature on the impact of market-inspired government reforms of the NHS on equity in service provision was reviewed.

Chapter 4: Methodology

In this chapter, the methodology employed in this research project is described. The first section lays the foundation by providing an overview of the diversity of methodological approaches applied in studies of organizational culture. The next section presents the justifications for the methodological choices that were made in this research project. This section argues the case for why a particular approach was taken in this research. After this the mixed methods research design is set out in detail and the reasoning behind methodological choices is explained. This section also discusses some of the ethical issues that arose in the course of the research and how they were addressed. Lastly the plan for statistical analysis is articulated.

4.1. Methodological Implications of Conceptualizations of Organizational Culture

In this section, the methodological implications of the principal conceptualizations of organizational culture are discussed. Culture studies can be divided into different categories on the basis of ontological assumptions made about the nature of culture and epistemological assumptions made about how to study culture. Two broad classifications can be discerned - the objectivistic, positivistic, quantitative paradigm and the subjectivist, interpretivist, qualitative paradigm. A third hybrid tradition that combines the two approaches is slowly emerging. This section discusses these issues in detail. The history of the various methodologies employed in culture research is also traced.

On the basis of ontological assumptions about the nature of culture, organizational culture studies can be divided into two groups - objectivistic and subjectivistic (Janicijevic, 2011). Objectivistic views assume that organizational culture exists as a discrete entity, that culture is a property that an organization *has* (so, an organization *has* a culture), and that culture serves a distinct purpose and function for the organization (Janicijevic, 2011). Subjectivistic views in contrast, treat organizational culture as something that an organization *is* (an organization *is* a culture rather than *having* a culture). From this perspective, organizational culture is not a discrete entity having a reality of its own independent of the organization but is part and parcel of the organization itself. Since culture does not have an independent, objective existence, it can only be known through a subjective interpretation of its content. Moreover, a culture need not have a specific instrumental rationale for its existence (Janicijevic, 2011).

Janicijevic (2011) makes a further classification of organizational culture studies on the basis of the epistemological assumptions made by the authors of these studies about the nature of human knowledge. These epistemological assumptions are closely linked to ontological assumptions about the nature of organizational culture. Here again, two broad classes may be discerned – positivistic and interpretivist. The positivistic perspective assumes that culture, as an object with a discrete reality of its own, can be 'positively identified, described, and measured by an objective categorical apparatus independent from it' (Janicijevic, 2011; p. 75). Here, the researcher is a neutral, objective and distanced observer who tries to draw a faithful picture of an objective reality external to, and independent of, herself. This is also known as the *etic* perspective (or the organizational outsider's view) in cultural anthropology (Nanda and Warms, 2002; p. 11 - 14). The positivistic paradigm is allied with the objectivistic ontological position and results in quantitative approaches.

In contrast, the interpretivist epistemological perspective assumes that 'organizational culture cannot be positively identified and measured, but only interpreted' (Janicijevic, 2011; p. 75). Culture exists inside people's minds, not outside of them. As something that exists essentially in people's minds and is only partially reflected in symbols, behavioural patterns, etc., culture can not be known directly; it has to be interpreted; these interpretations are by necessity

subjective. 'Culture is explored by understanding, and not by measurement' (Janicijevic, 2011; p. 75). In order to infer the perspective of 'culture-bearers' accurately, the researcher must get close to the culture and even become a part of the culture (Allaire and Firsirotu (1984), p. 198; Janicijevic, 2011). This is also known as the *emic* perspective in cultural anthropology (the organizational insider's view or the *native* view) (Nanda and Warms, 2002; p. 11 - 14).

The goal of objectivistic, positivistic and quantitative research is to measure culture precisely in ways that can be replicated, and to formulate general statements about culture. The intention of subjectivistic, interpretivist, qualitative approaches is to capture the nuances, subtleties, particularities and distinctiveness of cultures in different organizations.

The early phase of organizational culture research was marked by a preference for qualitative methods. According to Meyerson (1991), 'culture was the code word for the subjective side of organizational life . . . its study represented an ontological rebellion against the dominant functionalist or 'scientific' paradigm' that had dominated organizational studies till then (p. 256). Till then, studies of organizations had been characterised by an emphasis on positivism, quantification, and managerialism (Denison, 1996). The divergence from positivistic approaches was based upon the premise that culture was not an objective fact existing out there. Keesing (1974) sums this up well when he says that ' "culture" does not have some true and sacred and eternal meaning we are trying to discover; but that like other symbols, it means whatever we use it to mean; and that as with other, analytical concepts, human users must carve out - and try to partly agree on - a class of natural phenomena it can most strategically label' (Keesing, 1974; p. 73). Sathe (1983) supports this argument when he says, in almost identical words, that culture 'does not have some true and sacred meaning that is to be discovered. Each view has its place, depending on what one is interested in... Reading a culture is an interpretive, subjective activity. There are no exact answers, and two observers may come up with somewhat different descriptions of the same culture' (p. 6, 7).

Starting with the premise that culture refers to 'deep, intangible phenomena' that cannot be easily 'objectified', most early studies of organizational culture used qualitative methods (Bellot, 2011; p. 10). Since the emphasis was on studying the subjective and unique aspects of

each culture, quantitative methods were deemed inappropriate (Bellot, 2011). Ethnography and participant observation were the favoured methods; the common practice was to focus upon one institution at a time (Bellot, 2011). In a study of rites and ceremonies used in organizations, Trice and Beyer (1984) identified rites of passage, of degradation, of renewal, of integration, etc., and claimed that these rites performed important social functions of socializing, integrating, creating identity, etc. Wilkins (1983) examined an organization's culture through the stories in circulation. He found that stories about founders and other key organizational figures served as examples and models of desirable behaviours. The stories were, thus, an informal means of persuading, moulding and controlling employees' behaviour. Clark (1970) studied organizational *sagas* at three well-known liberal arts colleges (Antioch, Reed, and Swarthmore) and traced their historical development and the evolution of their organizational characters.

Qualitative studies of culture had some limitations, however. They were time-consuming and their generalizability was limited (Bellot, 2011). These limitations led to a call for the use of quantitative methods in culture studies. To prepare the ground for the adoption of quantitative approaches, researchers began to question the premises upon which the dominance of qualitative approaches in culture studies was based. Tucker et al. (1990) critiqued the claim made by Evered and Louis (1981) and Schein (1985) that only qualitative methods such as in depth interviews and long-term ethnographic studies could reveal the culture of an organization. They questioned the assumption made by the proponents of qualitative methods that the culture of an organization was 'relatively inscrutable to the outsider' and, in consequence, difficult to uncover (Tucker et al., 1990; p. 5). They argued that the premise of an inscrutable culture could not be reconciled with the view, accepted by qualitative researchers, that cultural understanding was often used as the basis for judgments, instructions, actions, etc. To illustrate their point, Tucker et al. cited Schein's definition of culture as 'a pattern of basic assumptions...that has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think, and feel' (Schein, 1983; p. 14). If culture was something that could be taught and communicated to others, then, it was an explicit rather than a tacit understanding. Therefore, it was not as inscrutable as qualitative researchers had suggested.

In reply, qualitative researchers argued that organisational cultures were unique or *idiosyncratic* and context-specific; consequently, standardised instruments such as survey questionnaires developed remotely without considering the particular context of the organization were unsuitable for capturing the subtleties of that organization's culture (Tucker et al., 1990; p. 5). Tucker et al. countered this view by stating that though no two cultures were exactly alike, it was possible to identify dimensions of culture that could be generalised across most, or all, organizations, and which were relevant or important for many of them. Quantitative methods, they claimed, could reveal common or generalizable aspects of culture that qualitative methods such as ethnographies did not, and that this knowledge was valuable.

Proponents of qualitative approaches (Clark, 1985; Lincoln, 1985) argued that methods other than ethnography were 'epistemologically unsound' for the purpose of assessing organisational culture (Tucker et al., 1990; p. 5). They claimed that cultural understanding and beliefs existed at a very deep level and, therefore, demanded comparable depth of engagement and measurement. Tucker et al. responded by stating that this view was too restrictive and without precedent in organisational studies. They argued that this position was contrary to established conventions in empirical research, which had relied upon 'the convergence of multiple levels, methods, and measures' to further understanding (Tucker et al, 1990; p. 5).

Tucker et al. (1990) advanced more reasons in favour of the use of survey methods such as questionnaires in the assessment of organisational culture. The idea of comparing cultures, they argued, was intuitive and potentially valuable but qualitative studies did not facilitate comparisons or meta-analyses. In situations where in-depth qualitative approaches were not possible due to 'limitations of time, intrusiveness, human resources, or organisational policy', surveying employees with paper and pencil instruments could provide a practical alternative (Tucker et al, 1990; p. 5). Most importantly, quantitative approaches could facilitate the study of organisational culture as an independent variable and of its relationship to organizational performance, change management, product quality, productivity and innovation. These relationships were often of great interest to practitioners. Quantitative methods offered a significant advantage in making such analyses possible.

Methodological debates and 'paradigm wars' have continued in recent times (Jung et al., 2009; p. 1088). Qualitative researchers like Druckman et al. (1997) have questioned the suitability of questionnaires or survey instruments for measuring culture, arguing that in assessing an organization's culture in terms of categories or types decided in advance by the researcher there is a danger of missing out or distorting the actual dimensions of cultures existing in the organization. Denison (1996) asserts that the dominance of quantitative approaches to culture contradicts 'the epistemological foundations of culture research within organizational studies' (p. 620). Siehl and Martin (1990) note with some concern that the over-reliance on quantitative approaches poses the risk of oversimplifying and trivializing culture and reducing it to 'just another variable in existing models of organizational performance' (p. 274).

Recent years have seen a noticeable increase in studies employing quantitative methods (Jung et al. (2009); Chatman, 1991; O'Reilly et al., 1991); instruments for studying culture through quantitative approaches have also developed with rapidity (Denison & Mishra, 1995; Gordon & Di Tomaso, 1992). Jung et al. (2009) attempt to explain this trend towards the increasing use of quantitative approaches. They ascribe the growth in quantitative studies to the management consultancy background of many of the authors of popular studies of culture (for example, Peters and Waterman, 1982). As big corporations and consultancies have become interested in organizational culture, a quantitative and diagnostic perspective has been privileged. The motivation behind this trend seems to be the desire to use culture in solving practical management problems and to create an off-the-shelf product. Convenience also seems to be a factor: quantitative surveys can be administered and evaluated quickly whereas qualitative methods are more resource- and time-consuming (Jung et al., 2009).

Attempts have been made to bridge the divide by using mixed methods (Siehl and Martin, 1983; Mackenzie, 1995; Jackson, 1997; Zimmerman et al., 1993; Zimmerman et al., 1994). Mixed methods have become the preferred approach for rigorous assessments of culture (Bellot, 2011). According to Alvesson & Berg (1992), mixed methods offer better explanations of error variance and greater finesse in the refinement of culture as a construct. The use of mixed methods also offers more ways of analysing data (Fleeger, 1993). Ouchi and Wilkins (1985) praised this new '*hybrid energy* flowing from the confluence of several established methodologies with a variety of approaches to the idea of organizational culture', stating that

this confluence was resulting in the creation of 'a quite novel form of organizational scholarship' (p. 476). The use of mixed approaches, they added, marks 'a return to a concern for the whole of the organization, an interest in knowing not only about that which can be captured in a standardized regression coefficient, but in knowing also what can be described only in a lengthy quotation that reveals the native' s point of view' (Ouchi and Wilkins, 1985; p. 479).

In the preceding paragraphs, the methodological implications of different conceptualizations of organizational culture have been explored and discussed. Examined from an ontological and epistemological perspective, there are two main traditions in culture research – the objectivistic, positivistic, quantitative paradigm and the subjectivist, interpretivist, qualitative paradigm. A third hybrid tradition that combines the two approaches has emerged in recent years and is growing in strength.

4.2. Justification for Choice of Philosophical Assumptions and Approach in this Research Project

The previous section described the various methodological approaches employed in studies of Organizational Culture. This section describes the specific choices made in this research project and articulates the reasoning and the justifications for those choices.

The ontology and epistemology for this research project were objectivist: positivist epistemology and objectivist ontology (Schuh and Barab, 2008; Crotty, 1998), actually, a softened or moderate post-positivist or neo-positivist stance (Wong et al., 2011; Crotty, 1998). According to Schuh and Barab (2008 ; p. 71), an objectivist approach posits that 'the world is real and exists outside of the individual...Epistemologically, the mind functions as a mirror of nature, creating representations of the real world that require a correspondence to the external world. To know is to have these correct representations'. Crotty (1998) states that 'objectivism is the epistemological view that things exist as *meaningful* entities independently of consciousness and experience, that they have truth and meaning residing in them as objects

('objective' truth and meaning, therefore), and that careful (scientific?) research can attain that objective truth and meaning' (Crotty, ; p. 5-6).

As Janicijevic (2011) and Martin (2002) assert, approaches to the study of Organizational Culture fall broadly in two camps: those based on an objectivist epistemology and ontology and those based on a subjectivist epistemology and ontology . This research project is based on an objectivist epistemology and ontology. An objectivist ontology and epistemology was appropriate for this research firstly because Organizational Culture has been studied in this way by many other scholars. So there is a scholarly tradition of studying Organizational Culture through an objectivist ontology and epistemology. A second reason why this was appropriate was because the aim of this project was to produce findings that could be applied in healthcare practice. This was applied healthcare research. Because the ultimate aim was application in a wider setting, the generalizability and transferability of results were important. An objectivist ontology and epistemology were more compatible with an approach that sought to produce findings that were generalizable and transferable beyond their immediate setting and context.

Both the survey and the interview, *as used in this project*, were based on an objectivist ontology and epistemology (conventionally, surveys tend to be grounded in a positivistic, quantitative approach and interviews in a constructivist, qualitative approach). So, they were philosophically coherent, and complementary. Both the survey and the interview assumed that they were asking questions about *things* that were already out there, about events that had already taken place or were taking place, about facts that already existed. The aim of the survey and the interview was to grasp those external facts and represent them accurately.

Mixed methods were appropriate because organizational culture has been studied using mixed methods by many scholars. According to Bellot (2011), the use of mixed methods in Organizational Culture research has become a well-established tradition. Mixed methods were also appropriate because statistical methods alone cannot explain the results. They cannot provide insight into causes. Qualitative methods are needed for that. Yauch and Steudel (2003) suggest that another benefit of mixed-methods research is being able to explain the results of statistical analyses more fully, revealing the context and the story behind the numbers.

Combining qualitative and quantitative methods in a complementary way can result in deeper insight into organizational phenomena than each method could yield on its own (Greene, Caracelli, and Graham, 1989; Jick, 1979; Sale et al., 2002). While statistical analyses can help identify patterns of behaviour, qualitative methods such as interviews are needed to get at, to excavate the reasons underlying these patterns of behaviour. As Janicijevic (2011; p. 70), states, 'Organizational culture is a multilayered, multidimensional phenomenon, so different methods need to be used for exploring its various layers and dimensions.'

There are two traditions of research into culture: *etic* and *emic* (Janicijevic, 2011; Martin, 2002). Etic research is carried out from the perspective of the external observer. It is informed by an objectivist ontology and positivist epistemology. In this approach to research, the researcher defines in advance the dimensions of culture that are of interest. This formulation is made partly on the basis of past research, relevance and the goals of the research. The researcher then designs an instrument such as a questionnaire to quantify the presence of those dimension in the culture (Janicijevic, 2011). Clearly, the *etic* approach was followed in this research.

It should be noted that Organizational Culture cannot be quantified but the equity-supportiveness of Organizational Culture can be.

Jung et al. (2009) identified seventy qualitative and quantitative instruments for the assessment of organizational culture. However, it was decided to custom-design a survey for this research project because none of these was quite right for the aims of this project. Jung et al. (2009) concluded that 'there is no ideal instrument for cultural exploration. The degree to which any measure is seen as "fit for purpose" depends on the particular reason for which it is to be used and the context within which it is to be applied' (p. 1087). Bellot (2011) adds that there isn't one single best instrument for analysing organizational culture. Instead, the instrument needs to be tailored to the aims and requirements of the research. Further, as Jung et al. (2009) observe, 'Despite its intuitive appeal and widespread use by researchers, practitioners, and policy makers, there is little agreement as to how culture should be

conceptualized' (p. 1087). It might be added that there is even less agreement on how culture should be operationalized and measured. Davies et al. (2000) note that 'no consensus exists as to the range and definition of the organisational variables that fall within its purview [i.e., within the purview of Organizational Culture assessment surveys]' (p. 113). The lack of agreement among scholars on how to assess Organizational Culture and the consequent unreliability of existing instruments was another reason for designing our own.

4.3 Data Sources

This section indicates the kinds of data that were used to answer the research questions. The key sources of data are listed.

This research was about organizational culture around promoting equity, with special reference to cardiac and related health services. Since studying the culture of the entire organization was not feasible in a doctoral research project, the culture in a subset of the services was examined. The services that were looked at were those related to cardio-vascular disease as it is one of the biggest health problems facing the United Kingdom today (Hutton et al., 2008; Luengo-Fernandez et al., 2006; Hope, 1999).

Another reason for choosing cardiac-related services was the existence of inequity in the incidence of cardiac and related disorders; for example, there is a relationship between socio-economic deprivation and incidence of cardio-vascular disease (Pearson-Stuttard et al., 2012; Asaria et al. 2012; Bajekal et al., 2012; Hutton et al., 2008; Hamer et al., 2006). Thus, cardiac and related health disorders were thought to be particularly relevant to a research project centred on health equity. Moreover, cardio-vascular disease (coronary heart disease, but also cerebro-vascular disease such as stroke), Diabetes, smoking, and alcohol were closely related health issues, and the services were provided by a large number of hybrid and public organizations. Thus, the services that were examined were: cardiac rehabilitation, stroke rehabilitation, Diabetes education, treatment and rehabilitation, smoking cessation, and alcohol support.

The question motivating this research project was: Does organizational form (hybrid, public) have an effect on organizational culture around promoting equity in public and hybrid organizations providing publicly financed cardiac and related health services? In other words, were there systematic differences in the equity cultures of public and hybrid organizations?

This question was answered by an analysis of the cultures of public organizations (i.e., NHS) and hybrid organizations (i.e., social enterprises) in relation to the promotion of equity. Comparing the cultures in hybrid organizations with those in public organizations was expected to assist in identifying the effect of organizational form on equity.

For the purposes of this research project, 'hybrid organization' meant social enterprises providing publicly financed health care services, in particular, those social enterprises that had spun out of the NHS under the Right to Request programme. The logic behind restricting the definition of hybrid organizations to spun-out ex-NHS social enterprises was to minimise the differences between the public and hybrid organizations under examination so that the only change, the independent variable which was being manipulated, was the hybrid organizational form. Since these spin-offs from the NHS were constituted by people who were, until recently, a part of the NHS, there were expected to be no major differences between these ex-NHS and present NHS employees other than that the former were working under a different organisational form, that of hybridity.

The population of organizations for this research project was all the hybrid social enterprises that had spun out from the NHS and all public, i.e., NHS organizations. The sampling frame for the hybrid social enterprises that had spun out from the NHS was a comprehensive list obtained from the NHS Right to Request website and the website for the Cabinet Office Mutuals Information Service. The sampling frame for NHS organizations was NHS records of existing NHS branches.

To assess the extent of support for equity in public and hybrid organizational cultures, a mixed methods approach was used. The rationale for doing so is explained in detail below.

4.3.1 Rationale for the Use of a Mixed Methods Approach

Quantitative approaches are useful for identifying and describing broad patterns and trends in the data. One of the strengths of quantitative methods is that they permit general statements to be made about a broad category or categories of objects. In this research project, the first research question attempted to answer a factual, empirical question – are the organizational cultures of NHS organizations more supportive of equity than those of Social Enterprises? Quantitative approaches are suitable for answering these kinds of questions, so a survey was designed to assess the equity-supportiveness of different aspects of NHS and Social Enterprise organizational cultures. Since it was not practical to study the whole population due to the constraints of a doctoral research project, samples of NHS organizations and Social Enterprises were chosen. The quantitative approach taken in this strand enabled generalization to be made about the wider populations of NHS organizations and Social Enterprises.

The first objective of this research project was to be able to say, 'At this point of time, in general, or on the whole, X type of organizational culture is more supportive of equity than Y type of organizational culture', and this claim could be made from the data obtained about the two samples. This project aimed to provide a snapshot of the situation at a point in time, and the observational, cross-sectional design was suitable to achieve this purpose. Thus, the first objective of this research project, which was to make a descriptive, factual statement about which type of organization is better at promoting equity in public service provision, was accomplished.

The second objective of this research project was to explain any potential differences between the two types of organizations. It was thought possible before collecting the empirical survey data that there might be differences in the equity-supportiveness of NHS

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and Social Enterprise organizational cultures. This potential finding deserved an explanation, and the second objective of this research project was to explain any potential differences that might be found.

Cross-sectional quantitative methods are not good at answering explanatory, causal, *why* questions. Cross-sectional quantitative methods can identify correlations between variables (which can be suggestive of causal influences), however, the precise causal influence cannot be fixed with certainty (for example, due to an unknown third variable), and the direction of the causation remain unclear. Longitudinal quantitative study designs can make causal claims with more certainty, however that was not possible in this project due to the time and resource constraints of a doctoral research project.

Qualitative approaches, on the other hand, are more suitable for offering causal explanations. While qualitative methods suffer from the limitations of sample size and the *idiographic* nature of qualitative research (i.e., focusing on the unique and the individual, as opposed to *nomothetic*, i.e., focusing on the general, the typical), which affects their representativeness and generalizability, they can often extract information which can assist in answering causal questions. This was the approach taken in this research project. The qualitative strand was aimed primarily at eliciting information that might help explain differences in the equity-supportiveness of NHS and Social Enterprise organizational cultures but also, to a lesser extent, performing the function of triangulating the findings of the quantitative strand. Hence, there was a significant overlap in the questions asked in the survey and the interviews (though, of course, the manner of asking the questions differed considerably, being much more open-ended, unstructured, non-standard and participant-led in the qualitative interviews).

In the qualitative strand, semi-structured interviews were used to obtain detailed, in-depth information about cultural change in Social Enterprises and the impact of these changes on equity in service provision. For example, had Social Enterprise status led to a change in organizational goals? Had the new organizational goals affected the equity-related outcomes

of the organization? If so, how? These insights were meant to explicate the findings from the quantitative strand.

Thus, the two strands were intended to be complementary, to illuminate the findings from each approach and to lend robustness and strength to the overall findings. Ultimately, the aim was to combine quantitative and qualitative methods (as some of the best social research does) with a view to producing better, more usable research findings. The quantitative strand helped identify a broad pattern, and the qualitative strand helped to explain this pattern, and in the process, elucidate the organizational changes in ex-NHS Social Enterprises, which are the unknown quantity and the locus of interest of this project.

Bryman (2016) articulates some of the strengths as well as some of the disputes involved in mixed methods research. One of the biggest gains from using mixed methods is the opportunity for triangulation. The findings from one research method can be cross-checked against results from another research method, and if the findings from one method are corroborated by the other, researchers and consumers of the research can place greater confidence in the research findings. The results of the quantitative and qualitative strands can be compared for consistency; correspondence is likely to enhance the credibility of the findings and confer greater legitimacy on the research (Bryman, 2016).

Another advantage of a mixed methods strategy, Hammond (2005) suggests, is the ability to compensate for the limitations or imperfections inherent in any research method. Quantitative and qualitative approaches have their strengths as well as weaknesses. No method is completely free from limitation or bias. Using a combination of methods can help neutralise the biases and make up for the weaknesses in a single-method strategy (Harkness et al., 2006).

To take an example of the reason mentioned above, quantitative approaches tend to be good at producing what Bryman (2016; p. 645) describes as 'static' pictures of events. Cross-sectional quantitative research, for example, can identify a pattern or a trend, and produce a

snapshot of the state of affairs, at a given point in time. Qualitative approaches tend to be strong in revealing the social processes underlying the observable patterns captured by quantitative approaches (Bryman, 2016; p. 645). These social processes are sometimes subterranean and not easily observed. Qualitative approaches are suited to uncovering these *behind the scenes* processes, to use a dramaturgical metaphor. Thus, the limitation of one method is compensated for by the use of another, complementary method.

An associated benefit of mixed methods research, according to Bryman (2016; p. 644), is the potential for obtaining more complete findings. Quantitative and qualitative approaches are each better at investigating some phenomena than others, and using them jointly can result in one method filling in the gap left by the other, thereby producing a more complete picture than each method would have been able to do on its own. Using a combination of methods can assist in achieving both breadth and depth in the research findings, with broad-brush quantitative results illustrated and embellished with the richer, more detailed qualitative data, with abstract numbers made more concrete, immediate and colourful by engaging vignettes (Bryman, 2016).

An important reason for using mixed methods research is their suitability in accounting for unexpected or counter-intuitive research findings. For instance, when the proposed hypothesis in a quantitative research approach is inconsistent with the findings, qualitative approaches can help understand the unanticipated and puzzling results (Weinholtz et al., 1995).

The utilitarian argument is another important recommendation for mixed methods approaches (Pernice, 1996). Research oriented towards solving practical, real-world problems has, perforce, to engage with the complexity and messiness of issues in real life. Social policy research, in particular, has to confront the challenge of making its findings useful for both academics and well as policy-makers and practitioners. The complexity and multi-faceted nature of real-world issues and the aspiration to formulate practicable, effective, workable solutions imposes the challenge of designing research that fully gets to grips with, and

produces a deep understanding of, its complex subject matter. An integrated mixed methods approach is more likely to achieve this aim than a single-method approach (Pernice, 1996).

However, the use of mixed methods approaches is not free from criticism or contention. Some researchers (Hughes, 1990; Smith, 1983; Smith and Heshuius, 1986) have argued that a the choice of a research method is a commitment to a particular epistemological and ontological position, and that quantitative and qualitative research methods are based on very different, and fundamentally incompatible, views about the nature of social reality and ways of knowing it. For these researchers, there is an immutable irreconcilability in the epistemological and ontological assumptions that underpin quantitative and qualitative approaches which makes their integration philosophically unsound and unrigorous and likely to lead to flawed results.

A variant of this argument, supported by Morgan (1998), claims that quantitative and qualitative approaches are rooted in different *paradigms*, with each paradigm having its own set of values, assumptions and methods (Bryman, 2016; p. 636). There is internal consistency within each paradigm, with its values, assumptions and methods being compatible and aligned with each other. It is further argued by proponents of this view that the paradigms in which quantitative and qualitative approaches are grounded are *incommensurable*, i.e., essentially and permanently different and permitting of no integration (Bryman, 2016; p. 636). Integration between different research methods (for example, different types of quantitative methods such as survey and structured interviewing) is possible *within* but not *between* paradigms. Any attempt to bridge the gulf and join research methods *across* paradigms is doomed, and the integration is likely to be superficial and shallow (Bryman, 2016).

However, as argued by Bryman (2016), the claim that quantitative and qualitative approaches are wedded to certain eternally fixed epistemological and ontological commitments is hard to substantiate. Moreover, while the claim that different paradigms are incommensurable could be supported (depending upon the definition of the term *paradigm*), the assertion that quantitative and qualitative research methods constitute different paradigms is strongly

disputed. The many elements of commonality and overlap between quantitative and qualitative research methods make such a rigid distinction very difficult to sustain (Bryman, 2016; p. 636). In the face of these counter-arguments, the opposition to the use of mixed methods approaches breaks down. Moreover, the distinct advantages offered by mixed methods approaches make a powerful and compelling case for their use. Further, as explained below, the use of mixed methods approaches has a particular relevance to organizational culture research.

Mixed methods approaches are well established in the organizational culture literature. According to Yauch and Steudel (2003), a mixed methods approach produces more robust results than can be accomplished using a single approach for cultural assessment. They argue that a mixed methods approach is valuable in two ways. Using qualitative and quantitative data allows for triangulation of data, thereby reducing bias and increasing validity. Alvesson & Berg (1992) favour mixed methods approaches as they offer better explanations of error variance and greater finesse in the refinement of culture as a construct. Combining qualitative and quantitative paradigms in a complementary fashion leads to a deeper, more complete understanding of organizational culture because different methods can target different layers of culture. Janicijevic (2011) observes that 'organizational culture is a multilayered, multidimensional phenomenon, so different methods need to be used for exploring its various layers and dimensions' (p. 70).

Scott et al. (2003) claim that it is unlikely that any single instrument will provide a valid, reliable, and trustworthy assessment of an organization's culture, so, a multi-method approach will always be desirable: 'singular attempts to define and measure organizational culture are misplaced. Instead, a plurality of conceptualizations, tools, and methods are more likely to offer robust, subtle, and useful insights' (p. 942). Qualitative methods are advantageous for digging out detailed and nuanced information about culture but because of the few cases being studied it is not possible to generalize the findings to the wider population of organizations. Quantitative methods, on the contrary, draw upon a much bigger and more representative sample and enable cultural generalizations to be made about the wider population.

Ouchi and Wilkins (1985) argued eloquently for the use of mixed methods, praising the new '*hybrid energy* flowing from the confluence of several established methodologies with a variety of approaches to the idea of organizational culture', claiming that this confluence was resulting in the creation of 'a quite novel form of organizational scholarship' (p. 476). The use of mixed approaches, they added, marks 'a return to a concern for the whole of the organization, an interest in knowing not only about that which can be captured in a standardized regression coefficient, but in knowing also what can be described only in a lengthy quotation that reveals the native' s point of view' (Ouchi and Wilkins, 1985; p. 479).

A number of recent studies of organizational culture have utilised mixed methods (Siehl and Martin, 1983; Mackenzie, 1995; Jackson, 1997; Zimmerman et al., 1993; Zimmerman et al., 1994; Yauch and Steudel, 2003; Mannion, 2007). Mixed methods approaches have become the preferred approach for rigorous assessments of culture (Bellot, 2011).

Therefore, a mixed methods approach was employed in this research project to assess the extent of support for equity in public and hybrid organizational cultures. In keeping with this approach, the two main data collection methods were questionnaire surveys for the quantitative strand and semi-structured interviews for the qualitative strand.

This section indicated the kinds of data used to answer the research questions and argued for using a mixed methods approach. In the next section, the quantitative strand of the research design is discussed.

4.4 The Quantitative Strand

4.4.1 Design

This research project used an observational (cross sectional) research design to assess, and compare, cultures in hybrid and public organizations in terms of support for equity.

It has been hypothesized earlier that the organizational cultures of hybrid organizations may differ in their supportiveness for equity from the organizational cultures of public organizations. It follows logically from the hypothesis that individual cultural practices (that together constitute the culture of an organization) in hybrid organizations may differ in their supportiveness for equity from similar practices in public organizations. Thus, it was predicted that

a) The goals of hybrid organizations may differ in their supportiveness for equity from those of public organizations.

b) The performance assessment measures of hybrid organizations may differ in their supportiveness for equity from those of public organizations.

c) The decision-making processes in hybrid organizations may differ in their supportiveness for equity from those of public organizations.

etc.

These predictions, drawn from the hypothesis, were tested in the quantitative strand.

4.4.2 Sample of Organizations

The sample of organizations for the questionnaire survey was chosen with an eye to its representativeness. Quantitative questionnaire surveys tend to favour large random samples for statistical generalizations to be made to the wider population from which the sample has been drawn. According to Manheim et al. (2002), 'The more accuracy we want, the larger our sample

must be' (p. 115). There were about 45 hybrid organizations in existence at the time this project was carried out. Of the forty-five, 22 hybrid organizations together provided the services being examined in this project – cardiac rehabilitation, stroke rehabilitation, Diabetes education, treatment and rehabilitation, smoking cessation, and alcohol support. These 22 organizations were chosen as the sample of hybrid organizations. These organizations were expected to be representative of the wider population of hybrid organizations in terms of the characteristics that were important such as size, geographical location, services provided, clientele served, etc. A roughly equal number of NHS organizations (28) was selected for comparability. The matching NHS organizations were organizations offering the same services, based in the same geographical area, and serving the same population or populations with similar socio-economic and demographic profiles. For example, for the Locala social enterprise, the matching NHS organization was the Calderdale and Huddersfield NHS Foundation Trust. Thus, 22 hybrid and 28 NHS organizations were aimed to be sampled. It was originally planned that 15 employees from each organization would be surveyed. These employees needed to be working in one of the five services being examined in this project - cardiac rehabilitation, stroke rehabilitation, Diabetes education, treatment and rehabilitation, smoking cessation, and alcohol support. Thus, it was hoped that there would be a total of 750 responses to the survey. This sample size was arrived at on the basis of the existing organizational culture literature, consultation with supervisors and external academics, and a consideration of the time and resource constraints of a doctoral research project. Actually, approval to recruit could be obtained from only 12 NHS Trusts and 9 Social Enterprises within the time frame of this research project. A total of 124 survey responses was obtained (68 NHS and 56 Social Enterprise responses).

4.4.3 Sample of Participants

The survey was addressed to participants from public and hybrid organizations. The population of research participants for the survey was those who most influenced, and those whose behaviours were most influenced by, the environment for equity within the organization (Dobni, 2008). This type of sampling, described by Mackenzie (1995) as purposive sampling, is one where the researcher decides which members of the population are most likely to provide the answers to the research questions and then deliberately includes them in the sample. According to Mackenzie, the respondents must be knowledgeable about the issue at hand and

must also be reflective and articulate (Mackenzie, 1995; also Sackmann, 1991). In a health care organization, those whose work influences, and is influenced by, the equity culture of the organization are clinicians (doctors, nurses, etc.), managers, allied health professionals (physiotherapists, occupational therapists, etc.), and support staff (administrators, secretaries, etc.). In addition, any other members of staff who influenced the climate for equity within the organization were also appropriately qualified to participate. Therefore, statisticians, epidemiologists, equality and diversity officers, public health analysts, etc. were also eligible to participate because they may have provided an input into, and influenced, organizational efforts in promoting equity. From this population, a sample of respondents was drawn to take the survey.

4.4.4 Access / Recruitment

Participants were accessed by making contact with the Research and Development Office (R&D Office) or the management of the participating organizations and soliciting their cooperation. As advised by the supervisors, the first contact was made through a telephone call or a personal visit. During this initial contact, key personnel were identified and appointments set up. The researcher then attempted to contact these personnel, explain the research project and seek permission to conduct the research in their organization.

Once permission was granted by the R&D Office or the management to conduct the research project in their organization, the researcher identified a Local Collaborator at the organization (this was sometimes the Service Manager or the Departmental Head for the service concerned, or a senior member of staff working in that department such as a Consultant) to oversee and facilitate the conduct of the research. The researcher communicated to the Local Collaborator (Service Manager / Departmental Head / senior member of staff) the criteria for participation in the research. The Local Collaborator then identified the members of staff who were most suitable for the purposes of the research and were willing to participate and emailed them the web link to the online survey. If numbers were poor, the Local Collaborator was requested to suggest other potential participants. A snowballing strategy was occasionally used: respondents

were asked if they were willing to suggest names of acquaintances who might be interested in participating. Thus, using the contacts and referrals of participants, a longer list was compiled.

There were three main reasons why this recruitment strategy was adopted: a) minimising the burden on staff not involved in the project, b) greater accuracy in identifying potential participants and minimising the burden on the host Trust, and c) maximising the response rate. The first approach considered was for the Trust or the researcher to send a blanket email to all staff working in that department inviting them to participate. However, this approach had the downside of including in the blanket email those who were not interested in participating or were unsuitable for the purpose of the research. This was thought to impose an unnecessary burden on those members of staff. Therefore, an alternative approach was chosen, which was to request the Service Manager / Departmental Head / a senior member of staff to circulate the emails to staff working in that department. The advantage of this approach lay in the expectation that the Service Manager / Departmental Head / a senior member of staff would know the staff in the department well and would, therefore, be able to target suitable staff. It was thought that this approach would minimise the burden on staff not involved in the project. Secondly, for the researcher to email participants directly, prior informed consent would have had to be obtained from those members of staff before their work email addresses (which is their personal identifiable information) were passed on to an external researcher. This would have placed an additional burden on the Trust to get this consent before passing on this information to the researcher. Again, getting the Service Manager / Departmental Head to email colleagues was thought to get around this problem. Since they were senior employees of the Trust and in positions of oversight, they would have the relevant authorisations to view this personal work information and screen participants. And, lastly, it was thought that if the invitation to participate came from someone within the department, rather than an outsider, people were more likely to participate. Maximising response rate was the final reason in favour of circulation of emails through the Service Manager / Departmental Head / a senior member of staff.

It was understood that this recruitment strategy was not without its weakness, namely, recruitment bias. However, it was deemed to be the most pragmatic and feasible approach as it

minimised the burden of participation on the organization and individuals, and increased the likelihood of their agreeing to participate.

4.4.5 Administration of Questionnaire

The surveys were administered through an automated web-based system, the Bristol Online Survey. Online questionnaires were distributed via work email addresses to respondents who were requested to fill them out by a specific deadline. The questionnaire was expected to take about 10-15 minutes to complete. Respondents were asked questions about different aspects of their organization's work culture such as staff involvement in decision-making, the role of leadership, performance targets, etc. and how supportive they were of equity. A copy of the survey questionnaire is included in the appendix.

4.4.6 Analysis

The quantitative strand was about carrying out observational research, the independent variable or key factor being organizational form and the dependent variable being organizational culture around promoting equity. This research was trying to find out whether there was any association between organizational form (public or hybrid) and organizational culture around promoting equity.

For the quantitative strand, the unit of analysis was a single organization, which could have been either hybrid or public.

The SPSS software package was used to perform the necessary analyses (details of the statistical analyses are presented later).

Two pilots were conducted in the course of designing the study. The first was an exploratory mini-pilot carried out at a very early stage in the formulation of the questionnaire. It was undertaken with a small sample of about ten respondents drawn from NHS Trusts. The second pilot was a more formal one undertaken at a more advanced stage after the questionnaire had received input from various sources and had undergone several revisions. The results of the analysis of responses from the second, more extensive pilot are reported below.

4.4.7.1 Report of Reliability Analysis

A pilot was conducted on a group of 20 respondents. The sample for the pilot was a convenience sample consisting of respondents drawn from the NHS. The analysis of the responses from the pilot indicated a high degree of reliability in the questionnaire. Reliability was assessed using Cronbach's alpha coefficient and corrected item-total correlations.

There are two sub-scales in the questionnaire. Separate reliability analyses were carried out for both sub-scales. Results of the analyses are reported below.

4.4.7.2 Results of Reliability Analysis for Sub-scale 1

Sub-scale 1 consisted of items 9-18. The value of Cronbach's alpha for the overall sub-scale was 0.839. Using the principle that alpha values above 0.7 suggest acceptable reliability (Rattray and Jones, 2007; Moussaoui et al., 2004; Bland and Altman, 1997; Spiliotopoulou, 2009), the results indicated that the sub-scale as a whole shows good reliability.

'Alpha-if-Item-Deleted' values were calculated for each of the individual items. The results pointed to a high degree of internal consistency in the sub-scale. No significant changes to overall reliability were observed on deleting any of the items. For all items except two, a small decrease in overall reliability was observed, as was expected; for two items (Q. 14 and Q. 18), a very small increase in overall reliability was detected (to 0.841 in both cases). Since this was a minor change from the overall alpha value (and since the corrected item-total correlations for these two items were fairly high, being 0.323 and 0.315 respectively), it was not thought worthwhile to make any changes to these items.

Corrected item-total correlations were calculated to find out how scores on individual items correlated with scores on the test as a whole. Using the principle that values greater than 0.3 indicate acceptable reliability (Squires et al., 2011; Estabrooks et al., 2011; Rattray and Jones, 2007; Moussaoui et al., 2004; Nunnally, 1978), it was found that all the items had corrected item-total correlations greater than 0.3. All items except two had values in excess of 0.43 which showed quite high reliability; these two items were Q. 14 and Q. 18 (the respective corrected item-total correlations were 0.323 and 0.315; the 'Alpha-if Item-Deleted' value was 0.841 in both cases). Since the item-total correlations for both items were still high (> 0.3), and the 'Alpha-if Item-Deleted' values for these two items indicated a negligible increase in the overall reliability of the scale (to 0.841 in both cases), it was decided to retain these items.

Thus, the analysis indicated that the items appear to be consistent with each other and to be measuring the same construct.

4.4.7.3 Results of Reliability Analysis for Sub-scale 2

Sub-scale 2 consisted of items 20-31, 33, 35, 37(a), 38, 39, and 40(a). The value of Cronbach's alpha for the sub-scale as a whole was found to be 0.839. Again, using the principle that alpha values above 0.7 suggest adequate reliability (Rattray and Jones, 2007; Moussaoui et al., 2004; Bland and Altman, 1997; Spiliotopoulou, 2009), the results indicated that the sub-scale as a whole shows good reliability.

'Alpha-if-Item-Deleted' values were calculated for each of the individual items. The results of the analysis for sub-scale 2 also point strongly to a high degree of internal consistency in the sub-scale. All but two 'Alpha-if-Item-Deleted' values show a slight decrease in overall scale reliability. No significant changes to overall reliability were observed on deleting any of the items. Where a noticeable change in overall scale reliability was observed (0.819 and 0.820 for Qs. 35 and 26 respectively), it was found to be associated with high corrected item-total correlation values (0.654 and 0.623 for Qs. 35 and 26 respectively). Thus, there was enough reason to have confidence in the internal consistency of these items, and to retain them in the sub-scale. A small variation from this overall trend was observed in the case of Qs. 23 and 37. The 'Alpha-if-Item-Deleted' value for Q. 23 was 0.839 indicating no change in overall reliability if the item were to be deleted (and a corrected item-total correlation value of 0.205). The 'Alpha-if-Item-Deleted' value for Q. 37 was 0.843 (with a comparatively low corrected item-total correlation value of 0.178). Since the 'Alpha-if-Item-Deleted' value for Q. 23 indicates no increase in overall scale reliability if the item were to be deleted, and since overall scale reliability increases only marginally (by 0.004) if Q. 37 were to be deleted, it was decided to retain both these items. It was agreed that a decision on whether or not to utilize data from these questions in the final analysis would be deferred until the data collection process had been completed.

Corrected item-total correlations were calculated to find out how scores on individual items correlated with scores on the test as a whole. Using the principle that values greater than 0.3 indicate adequate reliability (Squires et al., 2011; Estabrooks et al., 2011; Rattray and Jones, 2007; Moussaoui et al., 2004; Nunnally, 1978), it was found that all but three items had corrected item-total correlation values greater than or very close to 0.3; well over half the items (11 items out of 18) had correlations greater than 0.4, thus, indicating high reliability; only three items had values significantly lower than 0.3. There three items were Qs. 21, 23 and 37 with corrected item-total correlation values of 0.241, 0.205 and 0.178 respectively (the respective 'Alpha-if-Item-Deleted' values were 0.838, 0.839 and 0.843). Since the 'Alpha-if Item-Deleted' values for these three items indicated, respectively, a decrease, no change, and a negligible increase in the overall reliability of the scale, it was decided to retain all these items.

<u>4.4.7.4 Conclusion</u>

Thus, it was concluded from the analysis of the responses to the pilot that respondents appeared to be answering the questions in a consistent manner, that each item appeared to be measuring the same construct as the others, and that there was no evidence that any item did not belong in the sub-scales. Therefore, it was decided to retain all the items in both sub-scales.

As a result of feedback from respondents, the order of some of the questions was changed with a view to making the questionnaire easier to complete. The wording of some of the questions and of the explanatory information was simplified. New text was added to increase clarity about the aims of the research. Since internal consistency of the individual items was high, it is expected that changing the order of the questions will not affect the reliability of individual items or of the scale as a whole significantly.

<u>4.4.8 Constructs Operationalized by the Sub-scales of the Survey Questionnaire</u>

The six sections in the questionnaire (each section representing a different sub-scale) correspond to different aspects of an organization's culture in relation to promoting equity.

Section 1 aims to identify key organization-wide internal systems that have a material bearing on its equity culture. These systems include whether the organisation has a strategy or plan to promote equity in the provision of care, whether the senior leadership (for example, the Board of Directors) has made an explicit commitment to equity, whether performance management processes, financial incentives, rewards etc. are linked to the promotion of equity, whether there is clear assignment of responsibility and accountability for the promotion of equity, whether the organisation's induction and training programs educate staff about equity-related issues, etc. While the emphasis of this section is on internal systems that influence its equity culture, an acknowledgment is made of the vital role of external

influences on the organization's equity culture through a question about whether the promotion of equity is a part of the contractual agreement with commissioners of services.

Section 2 is concerned with the collection of equity-related data and whether the data is analysed to support equity-promotion efforts. Without the right data, efforts to promote equity will not be optimally effective. Therefore, this section asks whether the organization routinely collects equity-relevant data (such as patient admission data or service user data on socio-economic status, age, gender, ethnicity, sexual orientation, disability, etc.). It also investigates whether equity in the provision of care is measured from the available raw data, whether equity data is monitored on an ongoing basis to track the organization's equity performance, and whether equity data is utilised to make changes in service delivery to improve equity outcomes.

Section 3 assesses the importance given to the promotion of equity by various categories of healthcare professionals (clinicians, managers, allied health professionals, and administrative staff). The purpose of this section is to find out how important these healthcare professionals consider equity to be (amidst all the other pressures and targets vying for their attention) and the degree of priority they attach to the promotion of equity in the provision of care.

Section 4 investigates the rigour with which the organization carries out equality impact assessments when making important organizational decisions, re-configurations or service re-designs. This section asks questions about the weight given to equity considerations while making important organizational decisions about the allocation of resources (human, financial) and in planning the organization and delivery of services.

Section 5 is the heart of the questionnaire and contains questions about the core cultural categories that influence equity in the provision of care. This section discusses the role of various key systems and processes within organizations and the extent to which they support equity. The core cultural categories examined in this section include individual performance targets, the role of the employee's immediate leadership (for example, their line manager) and

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the organization's senior management, the extent of front-line staff involvement in strategic organizational decision-making, the amount of bureaucracy and the ease and speed of decision-making in the organization, the amount of autonomy and discretionary power to adapt services that front-line staff have, and, finally, the role of the organization's mission, goals and values in supporting efforts to promote equity. It is recognised that the degree of influence that these cultural categories have on the promotion of equity will vary in different organizations. Therefore, the last question in this section asks respondents to assign weights to these categories to indicate their relative importance in influencing the equity culture in the organization.

Section 6 (Demographic Information) requests information about the personal characteristics of respondents thought to be relevant to shaping their views about the equity culture in their organization. Thus, there are questions about the respondent's professional role (clinician or manager), whether they work in an NHS organization or a Social Enterprise, the level of care at which they work (primary, secondary, or tertiary), the length of employment with the organization (which would correspond to their knowledge of the culture of the organization), their educational attainment, gender, ethnicity, disability, their political leanings, etc.

This section presented details of the quantitative strand of the mixed methods approach. In the next section, the qualitative strand of the research design is discussed in detail.

4.5 The Qualitative Strand

In this section, the qualitative strand is explained.

In the qualitative strand, semi-structured interviews were used to obtain detailed, in-depth information about cultural change in hybrid organizations and its impact on equity.

The qualitative strand examined hybrid organizations only and investigated whether, and how, culture had changed in these organizations since they spun out. Had hybridity led to a cultural change? For example, had organizational goals changed? Had the new goals affected the equity-related outcomes of the organization? If so, how? The qualitative strand, thus, aimed to examine cultural change in hybrid organizations.

4.5.1 Design

The qualitative strand employed a multiple-case study design. According to Yin (2003), the case study approach is highly suitable when 'a how or why question is being asked about a contemporary set of events over which the investigator has little control' (p. 9). The unit of analysis for the case for the study was a single hybrid organization (i.e., a health care social enterprise).

Definition and Selection of Cases

In this research project, five cases (five Social Enterprises) were chosen bearing in mind the need to obtain sufficient depth in data collection as well as the time constraints of finishing the data collection within the time allotted to a doctoral research project. The following criteria were used to select the five Social Enterprises (this is how the *cases* or *units of analysis* were defined (Yin, 2014; Baxter and Jack, 2008; Eisenhardt and Graebner, 2007)):

1. The organizations had to be Social Enterprise healthcare providers that had spun out from the NHS under the Right to Request scheme and that were providing publicly-financed NHS services.

2. The organizations had to offer the health services being studied - cardiac rehabilitation, stroke rehabilitation, smoking cessation, Diabetes education, treatment and rehabilitation, and alcohol support.

3. The organizations had to be willing to grant permission for their staff to be interviewed.

4. Geographical diversity: To achieve a diversity and breadth of opinion, Social Enterprises from different parts of the country were chosen. Thus, two Social Enterprises were based in the north-west of England, one in the north-east and two in the south of England.

5. Diversity of organizational size: The approach taken to sampling in the qualitative strand was that of maximum variation sampling, so Social Enterprises of different sizes were chosen. One of the Social Enterprises was a very small organization with less than a hundred employees. One was a very large organization, with over a thousand employees. The other three were mid-range organizations with 300-800 employees.

The cases (Social Enterprises) that were chosen were *representative* or *typical* cases (Bryman, 2016). These cases, as Bryman (2016) explains, *exemplify* a wider category of cases of which they are members, or social processes in which they participate. The cases were not selected for their uniqueness, extremeness or for being out of the ordinary; on the contrary, they were selected because they epitomised a broader social grouping to which they belonged. A second rationale for the chosen method of case definition was their assistance in illuminating social processes of interest to the researcher (Bryman, 2016). All these cases had recently implemented a process of externalisation from the NHS and the adoption of a Social Enterprise organizational model. It was interesting to know the impact that these organizational changes had had on equity in service provision.

Theories of marketisation of public services posit that privatisation typically leads to reduction of equity. The relationship between privatisation and equity is an unresolved and intriguing one. Though a considerable body of research literature exists on the subject, it is curiously divided and inconclusive about the nature of the relationship, and actual government policy seems to reflect this confusion. The definition of the cases was designed to examine the implications of privatisation for equity through the collection of empirical evidence (as opposed to ideological debate and argumentation), especially in a context in which it has not been studied before (few existing research studies have examined the impact of privatisation on equity in relation to Social Enterprises).

4.5.2 Sample of Organizations

The number of cases to be studied is an important consideration in a case study. According to Yin (2003), the number of cases to be studied in a multiple-case design should not be dictated by a statistical sampling logic which favours randomness and large sample sizes but by the need for replication - literal and theoretical. Yin does say, however, that, as with statistical sampling, a larger sample size yields greater certainty. He asserts that 'regardless of any resource constraints, if multiple candidates are qualified to serve as cases, the larger the number you can study, the better' (p. 77-78). According to Eisenhardt (1989), though there isn't any ideal number of cases, four to ten cases is viewed as an adequate sample size: 'With fewer than 4 cases, it is often difficult to generate theory with much complexity, and its empirical grounding is likely to be unconvincing, unless the case has several mini-cases within it….With more than 10 cases, it quickly becomes difficult to cope with the complexity and volume of the data' (p. 545). In this study, five cases were chosen bearing in mind the need to obtain sufficient depth in data collection as well as the time constraints of finishing the data collection. Thus, five hybrid organizations were studied.

4.5.3 Sample of Participants

A purposive sampling strategy was used for the qualitative strand, too. The questions were addressed to participants from hybrid organizations who most influenced, and those whose behaviours were most influenced by, the environment for equity within the organization (Dobni, 2008). This included clinicians (doctors, nurses, etc.), managers (including clinician-managers), and allied health professionals (physiotherapists, occupational therapists, etc.). One academic from the University of Huddersfield, an expert in Social Enterprises, was also interviewed.

The sampling procedure for interviews was to keep adding interviews till theoretical saturation was reached. According to Saks and Allsop (2007), theoretical saturation occurs when 'no new information is generated by subsequent interviews, and when the data reflect a conceptual richness that both accounts for 'variations' in the data and allows for detailed description of the 'processes' informants experience – as well as enabling the researcher exhaustively to analyze the relationships between concepts and the categories identified' (p. 77). It was estimated that about 25 interviews would provide sufficient data and would result in theoretical saturation. In fact, 27 interviews were carried out. Even though theoretical saturation was not reached, data collection had to be stopped due to the time constraints of a doctoral research project. Thus, approximately five individuals were interviewed from each organization.

Staff from different professional groups (clinicians (doctors, nurses, etc.), managers (including clinician-managers), and allied health professionals (physiotherapists, occupational therapists, etc.)) were interviewed. This helped in obtaining a diversity and breadth of perspectives. Emphasis was placed on interviewing frontline staff. This was important as cultural studies have traditionally privileged the views of top management. This also helped in assessing how policies focusing on equity made at higher levels feed through to the front line. An attempt was made to obtain a balanced representation of different levels of responsibility (for example, junior and senior staff).

The study also aimed to get a good age, gender and ethnic mix because these might also have an impact on the information one obtains about equity. The views of female staff about gender equity in health care provision may be different from that of male staff. Similarly, the views of a person from an ethnic minority community about ethnic equity in health care provision may be different from the views of a person from an ethnic majority community.

The setting for the interviews was the premises of the participating organization. In all cases it was the office or workplace of the participating individual. Privacy was ensured by requesting the booking of a separate room in advance.

4.5.4 Access / Recruitment

A similar approach to that used for the quantitative strand was followed in recruiting interviewees for the qualitative strand of the research.

4.5.5 Data Collection Method: Semi-structured Interview

A semi-structured issue-focused interviewing technique was used to collect the data (a copy of the interview schedule is included in the appendix). According to Sackmann (1991), issue-focused interviewing can help in bringing the deep, subterranean, often invisible aspects of culture to the surface. The issue focus narrows and specifies the exploration and provides a structure for the interview process. It also enables comparisons to be made as interviewees draw on the same reservoir of cultural knowledge and shared experience. It channels the attention of respondents to the same cultural aspects within a given organization and reveals their framework about the issue. Comparison of the views of interviewees helps separate idiosyncratic individual views from cultural views which are the shared views that are common to many interviewees. Further, comparison also facilitates identification of clusters of views that might correspond to various sub-cultures Sackmann (1991).

Sackmann (1991) advises that the issue should be made non-threatening to respondents. If they feel that their personal stake in the issue under exploration is high, their responses are likely to be biased in systematic ways. Important information may be withheld and socially desirable answers may be given. It was hoped in this research project that assuring participants of the anonymity of their responses and the confidentiality of the data they provided would go some way towards assuaging any concerns about expressing adverse remarks about the organization. Further, obtaining the support of top management for the project was also expected to help allay concerns.

The interview schedule was sent to the interviewee at least a week before the interview to allow the interviewee to reflect on the questions and to prepare relevant examples to support their answers. At the beginning of the interview, any questions about the purpose of the interview were answered and any gaps in understanding filled. Follow-up questions were used to probe and elicit a more detailed description and, thereby, come to a better understanding of the examples given (Edvardsson and Roos, 2001). The answers to the main questions in the interview schedule were probed further using questions such as:

a) What happened ?

b) When did this happen ?

c) Where did this happen ?

d) Who was involved ? Exactly what did they do ?

e) How or why was equity promoted or undermined ?

(Adapted from Flanagan, 1954).

4.5.6 Approach to Semi-structured Interviews

The interview guide (appendix 2) was circulated in advance to the interviewees so that they could reflect on the questions and come prepared to the interview with examples. It was also to ensure that the researcher was respecting sensitivities around organizational information, especially adverse information about the organization that the interviewee might be reluctant to share. It was also to minimise surprises. Interviews were carried out at the premises of the Social Enterprise or the office of the interviewee.

The interview guide had been piloted through two preliminary interviews to ensure that it was fit for purpose. While some clarification, re-phrasing or change of wording was occasionally necessary, no major changes to the interview guide were required over the course of the 27 interviews.

The interview began with the interviewer explaining the aims of the research and taking informed consent. Confidentiality and anonymity were emphasized, and the interviewee was encouraged to speak frankly and honestly. Participant Information Sheets and Consent Forms had been emailed in advance to the interviewee. The Consent Forms were signed by both the researcher and the participant. The interviewee's willingness for the interview to be audio-recorded was confirmed (in addition, the researcher also took notes by hand). The interview then proceeded.

The researcher learnt some important lessons in relation to recording interviews. At one interview, the researcher forgot to switch the digital recorder off. The researcher was doing back-to-back interviews on consecutive days. As a result of leaving the digital recorder on overnight, the recorder was completely drained of battery power by the time the researcher arrived at the second interview the next day. As the interviewee did not wish to defer the interview, the researcher conducted the interview but had to rely on taking notes by hand. While the researcher did his best to take notes, a significant amount of data from that interview was lost due to it not being recorded. This was an object lesson in always carrying the charger for the digital recorder to the interview. Since then, the researcher has always carried the digital recorder's supporting equipment to interviews, including the charger and the operating manual in case there are any technical malfunctions.

On another occasion, the researcher travelled to London to conduct some interviews. Upon arriving in London, on the morning of the interview, the researcher discovered that he had brought everything else but left the crucial digital recorder at home in Manchester. Thankfully, the researcher had an MP3 Player which had recording capabilities. As a result, the interviews were carried out successfully. However, that was a disaster narrowly averted as organizing those interviews had cost a lot of time and effort both for the researcher and the participants. That close escape taught the researcher to always carry a backup digital recorder and to prepare an interview checklist which the researcher referred to while preparing for any trip to carry out interviews.

The researcher adhered broadly to the structure of the interview guide. However, in the course of the interview, he often had to deviate from the pre-arranged structure when the interviewee anticipated later questions or the discussion naturally turned to them. A fair degree of flexibility was observed in the order of asking questions while ensuring that all the

important topics were covered. Follow-up questions, probes and prompts were used appropriately to discuss issues in detail.

Other important learning for the interviewer included keeping questions short, refraining from asking multiple questions at the same time, and avoiding leading statements or body language. The researcher learnt to restrain his responses and to behave like a disinterested observer so as not to influence the interviewee's responses through overly supportive or contradictory comments or body language. While a certain degree of responsiveness was unavoidable in the interests of building rapport, the researcher learnt to strike a fine balance between necessary filler words and head nods to express agreement and to keep the conversation going, and overly revelatory or judgmental verbal or physical gestures. This also helped ensure that what the researcher was obtaining was the participant's perspective and not merely a confirmation of the researcher's point of view. During the interview, the interviewees sometimes shared artefacts such as organizational reports, brochures, etc. and these were added to the store of data to be analysed.

This section articulated details of the qualitative strand of the research design. The next section identifies some of the important ethical issues that arose during the conduct of the research and how they were addressed.

N.B. The quantitative strand of the research design included both public organizations (i.e., NHS) and hybrid organizations (i.e., social enterprises) and involved a questionnaire survey of staff from both kinds of organizations. The qualitative strand examined only hybrid organizations (i.e., social enterprises) and consisted of semi-structured interviews with staff from hybrid organizations.

4.6. Ethical Issues

The principal ethical issues that arose during the conduct of the research were:

a) The first ethical issue was that of fairness in recruitment and the fairness of the inclusion and exclusion criteria used to select participants.

b) The second ethical issue was that of informed consent.

c) The third ethical issue was that of confidentiality.

d) The fourth ethical issue was that of the burdens and benefits of participating in the research.

Ethical approval was obtained from The School of Human and Health Sciences' Research Ethics Panel (SREP). SREP recommended some changes which were made. Separate ethical and management approval was obtained from each NHS R&D Trust and social enterprise. An NHS IRAS Form was completed along with individual Site-specific Information Forms for each NHS Trust. The R&D office staff at various Trusts also made suggestions which were agreed and incorporated into the project design.

As the project involved a questionnaire survey of, and interviews with, NHS and social enterprise staff, it was deemed to be a low-risk project. The main ethical issues arose in recruitment and ensuring anonymity and confidentiality for the responses of participants. The online survey was designed to assure respondents of anonymity and confidentiality. The Participant Information Sheet and Consent Form preceded the survey. Respondents were asked to confirm that they had read and understood the information sheet and gave consent to take part in the research before they were able to proceed to the survey itself. Responses from all the participants were pooled at one site without being classified by organization. It was, therefore, not possible to identify any individual from the responses because of the large sample size, consisting of a number of individuals sampled from each of several NHS Trusts and social enterprises. Encryption was added to the Bristol Online Survey account to enhance data security during transfer and ensure confidentiality of responses.

In respect of recruitment and access, the service manager or clinical lead was requested to circulate the survey via email to colleagues, and to nominate interviewees. Though this approach has its own biases, it was chosen as being the most practicable. Given that a

substantial amount of time (an hour or more) was being requested from busy healthcare professionals going through turbulent changes within their organizations and experiencing significant insecurity and anxiety, this approach was favoured as it minimised the burden on participating organizations and individuals. Before the interviews, the interviewer confirmed that the interviewee's participation was free and voluntary, and that there was no coercion involved. Assurances of confidentiality and anonymity were repeated to encourage participants to answer honestly. It was felt subjectively by the researcher that because of the balanced answers given by interviewees, including views both complimentary and critical of their organization, interviewees were answering questions truthfully and that there wasn't a systematic bias in favour of their organization.

The main challenges were administrative and organizational in carrying out a large-scale, complex mixed methods research project involving a large number of NHS Trusts and social enterprises. R&D approval had to be obtained from each of the Trusts. Moreover, agreement had to be obtained from each service lead. The approval process was lengthy and time-consuming, particularly, as many of the NHS Trusts and social enterprises were in the midst of major changes and re-configurations and the services were sometimes in the process of being tendered for anew. Therefore, making contact with the relevant people and obtaining access to them was difficult and time-consuming. Appointments had to be booked weeks or even months in advance. Moreover, participants had to be reminded several times periodically to get them to complete the survey.

Since these issues have been discussed in detail in the appropriate sections of the IRAS R&D and SSI application forms, they have not been stated here to avoid repetition and in the interest of concision.

4.7. Plan for Statistical Analysis

This section has been structured in the following way. In the first sub-section, the research questions that are aimed to be answered through the statistical analysis are stated. Next, the conceptualization of the outcome variables is explained. In the subsequent sub-section, the reasons that guided the choice of particular outcome variables and the exclusion of other possible outcome variables are set out. This process is repeated in the next sub-section for predictor variables, and the reasoning behind the choice of certain predictor variables and the exclusion of other potential predictor variables is presented. The selection of outcome variables is explained before the selection of predictor variables because the predictors were chosen for their ability to explain the outcomes. Next, the statistical techniques employed are discussed. Finally, the findings from the statistical operations are analysed in the context of the research questions.

This sub-section provided an overview of this section. The next section presents the research questions.

4.7.1. Research Questions

In this section, the questions that guided this research are stated.

The primary research question that this research project tried to address was: are NHS and Social Enterprise organizational cultures equally supportive of equity? In other words, were the cultures of NHS organizations (public organizations) more or less supportive of equity than those of Social Enterprises (hybrid organizations)?

The second question that this research project tried to address, and which was more implicit than explicit, was: how can organizations of all types (public, private, social enterprise) make healthcare more equitable? *At an organizational level, what really matters for equity?* Which organizational features can explain the differences between high-performing and low-

performing cultures (performance in terms of promoting equity)? Which organizational systems and practices improve equity?

At this point, it is worth making an observation about the level at which the data were collected and analysed. Equity can be examined at many levels: a) at the level of the individual, b) at the level of a department / service, and b) at the level of the organization. Examined at the level of the individual, equity data would involve observing the equity-promoting, equity-neutral or equity-reducing (discriminatory) behaviour of healthcare professionals. Examined at the level of the department / service or the organization, the data would consist of service-level or organization-level equity data (on access to care, quality of care, final health outcomes, etc.). In this research project, data was collected on perceptions of organizational equity culture at the individual (i.e., respondent) level which were, then, grouped to facilitate an organizational-level (NHS or Social Enterprise) analysis.

This section recapitulated the research questions that this analysis seeks to answer. In the next section, the reasons for defining outcome variables in a particular way are set forth.

4.7.2. Conceptualization of Outcome Variables

Five outcomes were proposed for analysis, to be analysed using either univariate or multivariate methods as appropriate. In this section, the reasons for defining outcome variables in a certain way are explained.

In this analysis, two types of outcome variables were deployed:

1. Organizational Mechanisms

2. Degree of Importance Given by Staff to Equity

Each of these is explained in more detail in the sections that follow.

4.7.2.1 Outcome Variable Type 1: Organizational Mechanisms

It is suggested that being a public organization (NHS) or a social enterprise is an important but not the only determinant of organizational equity performance (especially, considering that social enterprises spun out from the NHS very recently and have the same NHS-trained staff). It is proposed that, in addition, having organizational systems and mechanisms that promote equity also has a strong impact on organizational equity performance.

The concept of an *organizational mechanism* is a key one and is, therefore, explained in detail here. Collins and Porras (1994) define an 'organizational mechanism' as a concrete, tangible, specific and effective system that actually accomplishes the purpose for which it was established (p. 212-214). Mechanisms are effective; they have teeth. Mechanisms are tangible manifestations of abstract values and principles. They transform vague, general intentions into tangible, concrete systems that are visible and palpable. Mechanisms are drivers and catalysts of desired actions. They are experienced as strong forces for change by employees. Collins and Porras assert the centrality of effective mechanisms to the process of driving change and improvement: 'If you are involved in building and managing an organization, the single most important point to take away from this book is the critical importance of creating tangible mechanisms aligned to preserve the core and stimulate progress' (1994; p. 214).

Moreover, in the best organizations, the various mechanisms are aligned and work in harmony, thereby, producing a synergistic, multiplicative effect, like an orchestra, where the music as a whole is far greater than the sum of the sounds made by individual instruments. As Collins and Porras (1994; p. 209) state: '[Poorly performing organizations] often tolerate organization characteristics, strategies, and tactics that are misaligned with their admirable intentions, which creates confusion and cynicism...The builders of visionary companies seek alignment in strategies, in tactics, in organization systems, in structure, in incentive systems, in building layout, in job design - in everything...The gears and mechanisms of the ticking clock do not

grind against each other but rather work in concert - in alignment with each other - to preserve the core and stimulate progress'.

In great organizations, the institutionalization of mechanisms is never left to chance. It is a very purposeful, conscious, and deliberate process. Collins and Porras (1994) offer several examples of how great companies instituted organizational mechanisms to achieve their respective organizational goals and values. Walt Disney wanted his employees to practice the Disney values with fanatic zeal. However, he did not leave it to happen on its own by a fortunate coincidence or accident of nature. Instead, he established the Disney University and made attendance at the Disney Traditions seminars compulsory for every single employee of The Walt Disney Company. Hewlett-Packard (HP) had a set of principles for doing business known as *The HP Way*. HP didn't use *The HP Way* as a cynical public relations exercise to promote its ethical character. To ensure that *The HP Way* became its actual operating philosophy, the principles of *The HP Way* were translated into concrete objectives which formed the basis of performance reviews and promotions. To preserve the HP values over time, HP laid very strong emphasis on promoting staff from within to lead the organization. This ensured that only those employees who fully bought into *The HP Way* rose to positions of leadership and influence.

General Electric (GE) aspired to be a leader in technological development. GE executives did not merely talk about the importance of technological innovation, they set up one of the world's first industrial R&D laboratories. Boeing had a vision of being a pioneer and to lead the world in the field of aviation. However, it didn't just state this as an intention; instead, it committed itself, time and again, to what Collins and Porras (1994) call 'Big Hairy Audacious Goals' (p. 224 - 265), bold, daunting, and highly risky goals, failure in which could have been catastrophic and potentially fatal for the company. Over and over again, Boeing made big bets on projects such as the 707 and 747 commercial jets, using inspiring organizational goals as a mechanism to drive progress and stay constantly at the cutting edge of aviation technology.

Procter and Gamble (P&G) believed firmly in the value of self-initiated progress. So, P&G didn't just preach the idea of internally-driven progress; it established a system of internal competition between P&G's own brands. This system forced P&G brands to compete intensely

with each other in a Darwinian battle for survival, thus, stimulating progress from within the company. 3M wanted to encourage its employees to exercise initiative, innovate, and cultivate an entrepreneurial mindset. So 3M didn't merely articulate an inspiring vision of becoming a powerhouse of innovation. It created mechanisms to mandate that these values were practised consistently and rigorously, to encode them into the DNA of the company, to make them a way of life. It adopted a highly decentralised organizational structure, allowed employees to spend 15 % of their time on a project of their choosing, established an internal venture capital fund to finance promising ideas, and required all product divisions to generate at least 25 % of their annual revenues from new products introduced in the last 5 years (Collins and Porras, 1994).

Athena Swan is an example of an equity-promoting organizational mechanism. Awarded by the Equality Challenge Unit, Athena SWAN is a certification that recognises a university's commitment to advancing gender equality for women in higher education and research in the disciplines of science, technology, engineering, maths and medicine (Equality Challenge Unit, 2016). An equity-promoting organizational mechanism is a process or system that acts as a driver, a catalyst for the promotion of equity. It is reasonable to suppose that educational institutions that have Athena Swan accreditation will have less prejudice towards women than institutions that don't have the accreditation. There may be gender prejudice even in universities that have Athena Swan accreditation and some individuals in those institutions might think and act in prejudiced ways, but it is not unreasonable to expect that such prejudiced behaviour will be less likely in organizations that have an Athena Swan award. An Athena Swan award doesn't rule out gender prejudice completely; it, however, does make it less likely (at least, the more overt forms of discrimination). Moreover, achieving the higher levels of the award (bronze, silver, gold) requires the educational institution to demonstrate progress in furthering gender equity; an organization cannot remain at the same standard and obtain a higher award. So, the existence of equity-promoting organizational mechanisms (of which Athena Swan is a good example) is a good but not a perfect indicator of an organization's commitment to and seriousness about equity.

Next, the various kinds of outcomes data that might answer the research questions were considered. The first possibility was for the researcher to observe the patient-professional interaction and recognize equity-related behaviour when it occurred. It was challenging to

observe the behaviour of healthcare professionals in relation to equity in real life since the situations that call for equity-promoting behaviour are non-routine and unpredictable and cannot be known in advance. The challenge of identifying equity-reducing (i.e., discriminatory or prejudicial) behaviour was even greater as the presence of the researcher was likely to influence the behaviour of the healthcare professionals. Discriminatory behaviour was likely to be suppressed when healthcare providers knew that they were being observed.

The next best alternative was to look at the 'access to services' data, or the care quality data or the 'final health outcomes of patients' data. The researcher had proposed to do this but this approach was considered by the supervisors to be too complex, ambitious and resource-intensive given the constraints of a doctoral research project.

Therefore, it was decided to observe the presence or absence of organizational systems or mechanisms that promoted equity, and to use this as a yardstick to assess the equity performance of healthcare provider organizations. It was decided not to examine policies around equity, since policies might not be translated into action, but at actual systems that were already in place to promote equity. It was judged that these would provide better evidence of organizational seriousness and intent to promote equity. Thus, the first set of outcome variables consisted of equity-promoting organizational mechanisms. These outcomes were organizational mechanisms that differentiated high-performing healthcare organizations from low-performing ones. The mechanisms are listed below.

Organizational Systems and Mechanisms to Promote Equity:

a) Whether the promotion of equity in the provision of care is a formal board responsibility or not

b) Whether a Health Equity Audit (or a similar exercise) is performed for the service or not.

c) Whether performance management processes take into consideration the promotion of equity in the provision of care (i.e., whether financial incentives, recognition, etc. are linked to the promotion of equity) or not.

d) Whether there is a clear assignment of responsibility in the organization for the promotion of equity in the provision of care or not.

In this section, the argument for conceptualizing the first type of outcome variable in a particular way was set out. The next section presents the reasons why certain outcome variables (organizational mechanisms) were chosen and why others were excluded.

4.7.2.2 Reasons for the Inclusion and Exclusion of Outcome Variables (Organizational Mechanisms)

In this section, the criteria for selecting certain outcome variables (organizational mechanisms) and excluding others are stated.

4.7.2.3 Reasons for the Inclusion of the Chosen Outcome Variables (Organizational Mechanisms)

a) *Is the promotion of equity in the provision of care a formal board responsibility?*

The presence of this mechanism suggests that equity is a priority in decision-making at the highest level of management / leadership. Its presence indicates that the leader of the organization takes ownership of the equity agenda, throws their weight behind it, and personally drives it. This mechanism was included because the degree of seriousness, commitment and supportiveness for equity exhibited by the top leadership has a strong influence on the rest of the organization. The support of top management is a force that is likely

to have ripple effects across the whole organization. If the senior-most leadership show commitment to equity and define it as an organizational priority, their subordinates are likely to take notice. On the other hand, if the top leaders are not serious about equity, this attitude will percolate downwards in the organizational hierarchy.

b) *Is a Health Equity Audit (or a similar exercise) performed for your unit / service?*

This is a critically important equity-promoting mechanism. It is a catalyst and driver for real change and progress in reducing health inequalities. It used to be a mandatory requirement under the last Labour government but has now been made optional by the previous Coalition and the current Conservative governments.

c) *Do performance management processes take into consideration the promotion of equity in the provision of care (i.e., are financial incentives, recognition, etc. linked to the promotion of equity)?*

This question assesses whether equity is an explicit and routine part of employees' performance appraisals, whether the promotion of equity is an explicit part of employees' job descriptions and roles, whether concrete targets are set for equity promotion as for other areas in which the organization expects individuals to improve, and whether staff are performance-managed on how well they promote equity.

This mechanism was selected because behaviour that gets recognised and rewarded is usually what gets practised, regardless of what the organizational goals and plans are. This mechanism goes to the heart of economic thinking – incentives shape behaviour (Fehr and Falk, 2002). Behaviour that gets rewarded and that gets punished (invites disciplinary procedures) are crucial levers in shaping the behaviour of employees (Brickley et al., 1994; Jansen and Glinow, 1985; Worrell et al., 1985). This mechanism is the heart of organizational culture and organizational discipline.

d) *Is there a clear assignment of responsibility in the organization for the promotion of equity in the provision of care?*

The presence of this mechanism requires the organization to make it clear to all employees who is responsible for leading on equity-related issues in the organization. It means making the identity of the Lead on Equalities explicit and transparent to all staff instead of leaving employees to guess. It is about assigning responsibility and accountability for the promotion of equity clearly.

The presence of a dedicated Equalities Lead may reflect organizational priorities and indicate an organizational commitment to equity. If staff don't know whose role it is to lead on equity, they won't know who to go to in order to resolve any equity-related issues. The lack of clear lines of accountability might lead to diffusion of responsibility. Not knowing who to turn to may deter staff from reporting issues and concerns. It may cause delays in dealing with the issues.

In some organizations such as the larger NHS Trusts, this might mean having a separate, dedicated individual, team or office that leads on equity-promotion. A dedicated Equalities person may not be financially feasible for the smaller Social Enterprises (some with 25-50 employees) who are trying to make do with fewer staff as part of their efficiency drive. In such organizations, this role might be handled by someone who also handles other responsibilities (it might be a part of someone's overall portfolio of duties). It is worth remembering that NHS organizations are, typically, much larger organizations and, therefore, might reasonably require a full-time person to coordinate and deal with equity issues in various departments. Social Enterprises are much smaller and this responsibility may be part of the role of someone who also performs other duties and tasks. While having a dedicated Equalities Lead isn't necessary, it should be clear to all staff who is in charge of equity and who has ultimate responsibility and accountability for equity.

<u>4.7.2.4 Reasons for the Exclusion of Other Potential Outcome Variables (Organizational Mechanisms)</u>

In this section, the reasons for not choosing the other possible outcome variables (organizational mechanisms) are stated.

a) *Do the organisation's induction and training programs educate staff on equity-related issues?*

Basic Equality and Diversity training is mandatory for all NHS and Social Enterprise staff (Social Enterprise staff continue to receive NHS training) to attend. However, this question was about more than just the mandatory annual training or a one-off tick-box course. The scope of this question was more around ongoing education and focused training to foster a deeper understanding of organization-specific or service-specific equity-related issues and how to deal with them. Organizations that have equity-relevant training in place create more awareness and sensitivity in their staff to equity-related issues. Education on equity (whether formal, structured and comprehensive or *ad hoc* and piecemeal) is one of the more significant determinants of equitable practice.

However, the question asked in the survey did not make it adequately clear whether it was about one-off training courses or ongoing education. Both one-off training events and ongoing education were covered by it, so, this question could not adequately distinguish between organizations which invest in ongoing, continuous education and those which didn't. Hence, this mechanism was not included in the final analysis.

b) *Is the promotion of equity in the provision of care a part of the contractual agreement with commissioners or funders?*

This is not within the control of healthcare provider organizations and, thus, not an organizational mechanism or system that they can implement. Hence, it was excluded.

c) *Does the organisation have an explicit strategy or plan to promote equity in the provision of care?*

The question about the presence of Health Equity Audits (which is one of the mechanisms included in the analysis) already provides this information: a Health Equity Audit is an explicit strategy or plan to promote equity in the provision of care. This question doesn't add much new information. Further, plans to promote equity can remain on paper. Therefore, this question was excluded from the main analysis.

 d) *Can equity-related issues be raised easily by staff?*

There is already a well-established complaints policy for patients and staff to follow in all NHS-contracted organizations, so, it is not clear whether this question would have elicited any useful information. Also, there probably are, by now, whistle-blower policies within all NHS-contracted organizations, especially, after the shockingly poor quality of care and neglect of patients at the Mid-Staffordshire NHS Hospital Trust. Front-line staff can talk to their immediate line managers about any concerns they have. So, again, it is not clear whether this question would have added any new information. Moreover, it is not certain that this finding can be converted into a new organizational practice, as all NHS-contracted organizations probably already have mechanisms for staff to report anonymous feedback about any care-related issues.

4.7.2.5 Outcome Variable Type 2: Degree of Importance Given by Staff to Equity

The preceding section defined the first type of outcome variable used in this analysis: the presence (or absence) of equity-promoting organizational mechanisms. This section defines the second outcome variable used in this analysis: the importance given by staff working in these healthcare provider organizations (NHS and Social Enterprise) to equity. This included both

the importance given by staff to equity in the provision of care *generally* and the importance given by staff to equity *specifically* in the making of organizational decisions around the organization and allocation of resources. It was assumed that the importance given by staff to equity would be related to equitable behaviour. If staff in one type of organization (NHS or Social Enterprise) gave more importance to equity (i.e., if they valued it more), they were likely to be more equitable in their practice.

Four categories of healthcare staff (clinical, managerial, allied health professions, and administrative) were asked to report the degree of importance that they gave to equity *generally* in the provision of care. They were also asked to report the degree of importance that they gave to equity *specifically* in organizational decision-making (allocation of resources, planning and organization of services). These questions asked about the extent to which Equality Impact Assessments or considerations of equity were applied to major organizational decisions that affected the care that service users received – financial decisions, or decisions involving the re-structuring or re-configuration of services, or changes to the care pathway. The questions asked in the survey to elicit this information are stated below.

<u>Category 1</u>

The questions below indicate how much importance various classes of healthcare professionals give to equity in the provision of care *generally*.

14. How much importance do clinicians in the organization give to the promotion of equity in the provision of care? Please select an option from the list of options below to indicate the degree of importance given by clinicians to the promotion of equity in the provision of care.

15. How much importance do management in the organization give to the promotion of equity in the provision of care? Please select an option from the list of options below to indicate the degree of importance given by management to the promotion of equity in the provision of care.

16. How much importance do allied health professionals in the organization give to the promotion of equity in the provision of care? Please select an option from the list of options below to indicate the degree of importance given by allied health professionals to the promotion of equity in the provision of care.

17. How much importance do administrative staff in the organization give to the promotion of equity in the provision of care? Please select an option from the list of options below to indicate the degree of importance given by administrative staff to the promotion of equity in the provision of care.

Category 2

19. Please select an option from the list of options below to indicate how important equity considerations are in the allocation of resources (human, financial, infrastructural).

21. Please select an option from the list of options below to indicate how important equity considerations are in planning the organization of services.

23. Please select an option from the list of options below to indicate how important equity considerations are in planning the delivery of services.

The two categories of responses mentioned above were combined to create a composite score because the questions had a similar structure and were tapping into the same construct. A Reliability Analysis and a Factor Analysis were carried out as preliminary checks to ensure that the responses to these seven questions were internally consistent and that they cohered around a single factor. Both these analyses supported the decision to create a composite score.

However, the single component generated by the factor analysis was not easily interpretable. Hence, a composite score was derived based on the equal weighting of items, and a Mean score for the seven items was calculated.

In this section, the outcome variables were defined, and the process of selection of certain outcome variables was explained. In the course of this analysis, it will be shown that the two types of outcome variables (equity-promoting organizational mechanisms and the importance given by staff to equity) are consistent with each other. Having specified the outcome variables, the predictors are now defined.

4.7.3 Conceptualization of Predictors and Criteria for Inclusion and Exclusion of Predictors

The predictor variables were defined as features or characteristics of organizations that influenced the creation of equity-promoting organizational mechanisms which, then, had an impact on equity-promoting behaviour by healthcare professionals.

This section lists all the predictors that were considered for selection. The predictor variables could have been chosen from two categories:

1. Cultural Categories

2. Demographic Variables

The questions that could have been chosen from each of the two categories are listed below.

4.7.3.1 Potential Choices from the Cultural Categories (Qs. 24-32 in the questionnaire)

Individual performance targets

Role of immediate leadership

Role of leadership by the top management

Extent of involvement in strategic decision-making

Ease of decision-making

Amount of autonomy

Organizational mission

Organizational goals

Organizational values

4.7.3.2 Potential Choices from the Demographic Variables (Qs. 34-47 in the questionnaire)

Professional role / Job Title

Nature of Role (Clinical / Managerial)

Clinical department / specialism

Level of care at which you work (primary / secondary / tertiary)

Length of employment with the organization (years and months)

Departmental tenure: the length of time for which you have worked in your present department (years and months)

Type of health care organization do you work in (The National Health Service (NHS) / A Healthcare Social Enterprise)

Level of care provided by the organization (primary / secondary / tertiary): (select all that apply)

Age

Gender

Ethnicity

Disability

Level of education (the highest educational qualification achieved)

Political values (left, right, centre)

4.7.3.3 Preliminary Data Screening

The rationale for limiting the total number of predictors: The number of predictors was limited by the total number of responses. Given that there were 124 responses to the survey, the total number of predictors that could be supported was considered to be about 8 (Green, 1991). The main reason for limiting the number of predictors was that with more than about 8 predictors there was a risk of *over-fitting* the model, i.e., creating a model which fit the sample data too well. Over-fitting a model to the data has the disadvantage of allowing sampling artefacts to have an undue influence on the regression model and may reduce the model's transferability to other samples. Therefore, it was decided that the total number of predictors that could be reasonably supported by the size of this dataset was about 8. It will be seen that the actual number of predictors finally retained was even lower, thus, lending strength to the model.

An important selection criterion for predictors was that they had to be potentially associated with all five outcome variables (in a manner suggesting a potentially causal link, even though this could not be established conclusively one way or another with this observational research design). Thus, a key test of each predictor variable was that it should be reasonably expected to have an impact on all five outcome variables. One of the aims of the analysis was to evaluate the relationship between the potential predictors and the outcomes. The criteria for selecting the predictor variables are summarised below.

4.7.3.4 Summary of Selection Criteria for Predictor Variables

a) The predictor variables should be capable of influencing (and, therefore, correlated with) one or more of the outcomes.

b) The predictor variable should be theoretically likely to affect the equity culture of the organization.

c) There should be enough frequencies in all the levels of the categorical predictor variables (after combining categories, if necessary) for reliable comparisons to be performed.

d) The predictor variable should not be naturally controlled for in the sample.

In the following section, the reasons for excluding certain predictor variables are explained.

4.7.3.5 Reasons for Exclusion of Certain Possible Predictor Variables

The variable *Role of Immediate Leadership* was excluded because it was not expected to be associated with all the outcome variables. In other words, the reason why this potential predictor variable was not included is because it was not considered to be potentially influencing in a causal way all the outcome variables. For example, one of the outcome variables is *whether equity is a formal board responsibility or not*. Clearly, most staff members' immediate leaders cannot influence whether equity is made a formal board responsibility or not. Since *Role of Immediate Leadership* cannot explain each of the outcome variables, it was left out.

Individual Performance Targets, *Extent of Staff Involvement in Strategic Decision-making*, *Ease of Decision-making* and *Amount of Autonomy*, too, were left out for similar reasons. For example, the equity-supportiveness of employees' individual performance targets clearly has no bearing on whether the organization makes equity a formal board responsibility or not. *Ease of Decision-making* and the *Extent of Staff Involvement in Strategic Decision-making* do not lead directly to the creation of equity-promoting organizational mechanisms. Neither do they influence healthcare staff to give more importance to equity. Therefore, these variables were excluded from consideration as predictor variables.

It is worth noting that while these variables do not function as predictors, they may function as either enabling factors or disabling ones. While they may not have a direct relationship to equity-promoting organizational mechanisms, they can facilitate or obstruct the creation and operation of such mechanisms, and support or hinder equity-promoting behaviour by staff. They can speed up or slow down individual and organizational efforts to promote equity. For example, if a member of staff wishes to introduce an equity-promoting organizational system such as a Health Equity Audit in a highly bureaucratic organization where organizational decisions of this nature require scores of meetings and take months and months to be approved, it is not very likely that the person will succeed or feel motivated to persist. If the organization does not involve staff in strategic decision-making, and the leadership decide to introduce Health Equity Audits throughout the organization, getting staff engaged in and willing to whole-heartedly implement such equity-promoting initiatives will be difficult. If a service manager wishes to introduce Health Equity Audits for her service, but the organization does not grant staff operational autonomy and rejects her proposal, an idea that could potentially promote equity might never see the light of day.

These three examples suggest that the variables mentioned earlier had the power to aid or thwart equity-promoting initiatives. Therefore, while they were not included in this analysis as predictor variables, it was recognized that they might function as potential mediating variables. A meditational analysis incorporating these variables was considered; however, it was deemed to increase the complexity of the analysis more than was desirable and was, therefore, proposed to be included in future research. It should be noted that while these mediating variables are

included in the conceptual model presented later, meditational analysis was not carried out in this project.

Role of Leadership by Top Management was ruled out because of a possible tautology. Equity being made a formal board responsibility (which is one of the outcomes) is almost identical to saying that there is support from seniormost management. Including the predictor variable *Role of Leadership by Top Management* would have meant saying that X causes X, hence, it was excluded.

Some predictor variables were excluded because there were not enough responses in all the categories. For example, the predictor variable *Disability* had two main categories: *No Disability* and *Some Form of Disability (Dyslexia, Mental illness, Sight Impairment, etc.*' There were 105 responses in the *No Disability* category and only 6 responses in the *Some Form of Disability* category. Since there weren't enough responses in all the categories to make reliable comparisons, the predictor variable *Disability* was excluded. For the same reason the predictor variable *Ethnicity* was excluded.

A second reason for excluding some predictor variables was because they were too closely related to the major predictor variable *Type of Organization*, i.e., there was possible collinearity and confounding of effects. Including collinear variables can result in model instability. To clarify, *Type of Organization* has two possible responses: NHS organizations and Social Enterprises. Responses to certain predictor variables such as *Length of Employment with the Organization* and *Departmental Tenure* (the length of time for which you have worked in your present department)' were consequences of the type of organization to which a respondent belonged. Since Social Enterprises are relatively young organizations (having been launched in 2008) in comparison to NHS organizations, employees of Social Enterprises would naturally report less time spent with their respective organization and department. There is likely to be a lot of shared variance between responses to the predictor variable *Type of Organization* and responses to the predictor variables *Length of Employment with the Organization* and *Departmental Tenure*. These variables are not sufficiently independent of each other, so, they are likely to give rise to a confounding of effects.

The predictor variable *Level of Education* (the highest educational qualification that you have achieved)' was too highly correlated with the predictor variable *Type of Organization*. Most of the NHS organizations sampled in this project were acute NHS Trusts whereas most of the Social Enterprises were community healthcare providers. Acute NHS Trusts provide more complex healthcare services than Social Enterprises. It is reasonable to expect that providers of more complex care will have more specialist qualifications and will be more highly qualified and educated. Therefore, it was thought that the predictor variable *Level of Education* was too closely bound up with the predictor variable *Type of Organization*, and, hence, excluded.

Another predictor variable *Professional Role / Job Title* was excluded for the same reason. The response categories for this variable were: Doctor, Nurse, Allied Health Professional and other medical professional categories, and Manager (and administrator). Again, NHS Trusts, being providers of more complex healthcare services, had a much greater proportion of doctors than Social Enterprises. Therefore, any difference in responses to the question of *Professional Role / Job Title* was likely to be an effect of the type of organization to which a respondent belonged. The predictor variables *Type of Organization* and *Professional Role / Job Title* weren't sufficiently distinct; there was a likelihood of considerable overlap. Therefore, the predictor variable *Professional Role / Job Title* was excluded. Other predictor variables *Level of Care at which You Work* (primary / secondary / tertiary) and *Level of Care Provided by the Organization* (primary / secondary / tertiary) were ruled out for the same reason.

Some predictor variables were excluded because there was no theoretical reason to expect them to result in differences in the equity-supportiveness of organizational cultures. The predictor variables *Age* and *Gender* were excluded from the main analysis because there was no theoretical reason to expect that younger and older staff, or men and women, would be systematically more or less equitable in their behaviour.

Some predictor variables such as *Gender, Clinical department / Specialism, Nature of Professional Role - Clinical / Managerial*, and *Political Values* were excluded because there

was an equal and even split across the sample. These variables were naturally evenly and approximately equally distributed between the comparison groups and, therefore, were naturally controlled for. Therefore, no attempt was made to account specifically for these variables.

The preceding section explained the reasons for excluding certain predictor variables. In the next section, the reasons for including certain predictor variables are explained.

4.7.3.6 Reasons for Inclusion of Certain Possible Predictor Variables

The first predictor to be included was *Type of Organization* (NHS or Social Enterprise). Of course, *Type of Organization*, by itself, does not explain the differences in the equity outcomes of organizations. Merely being a public, private, or social enterprise healthcare provider does not make an organization more innovative or equity-promoting. There are many private sector companies that do not innovate and offer poor quality service as well as those which provide exceptional service and high quality of care. Similarly, a public organization may ostensibly have an aim of serving the public and promoting social justice and equity but, in actuality, it may deviate from its aim, for ex., at the Mid-Staffordshire NHS Hospital Trust. It is proposed in this analysis that whether an organization is public, private or social enterprise explains only partially the differences in the equity-related behaviour of their staff and their equity outcomes. It is suggested that, in addition, it is their different organizational dynamics that lead to differences in their equity outcomes, and that it is their different organizational dynamics that explain why one organization, or one class of organizations, is better at promoting equity than another. Since this research project was attempting to find out whether a particular type or class of organization (NHS or Social Enterprise) was linked with a certain kind of organizational dynamics which promote equity, *Type of Organization* (NHS or Social Enterprise) was proposed as the first predictor.

The equity-supportiveness of *Organizational Mission, Organizational Values and Organizational Goals* was considered next. All three variables were capable of being predictor

variables as they were all likely to have an impact on each of the five outcome variables. For example, an equity-supportive *Organizational Mission* could result in a) equity being made a formal board responsibility, b) in Health Equity Audits being done regularly by the organization, c) in the clear assignment of responsibility for the promotion of equity, d) in the design of employees' performance management processes to improve individual and organizational equity performance, and e) in staff giving more importance to equity generally in the provision of care and in the making of specific organizational decisions. Similarly, *Organizational Values* and *Organizational Goals* could have an impact on each of the outcomes. Therefore, all three variables - *Organizational Mission, Organizational Values and Organizational Goals* - were considered to be potential predictor variables.

It is worth noting at this point that the predictor variable *Type of Organization* does not impact on the outcomes in the direct way that *Organizational Mission, Goals and Values* do. However, *Type of Organization* can have an influence on the equity-supportiveness of *Organizational Mission, Goals and Values*. Therefore, *Type of Organization* is, perhaps, best thought of as a more upstream influence. Keeping this variable was important because it was required to answer the primary research question about the distinctions between NHS organizations and Social Enterprises.

One of the two possible predictor variables *Organizational Mission* and *Organizational Goals* (Qs. 30 and 31 in the questionnaire) was dropped from the analysis. Though there is a subtle distinction between these two questions, it was anticipated that they might have been interpreted and answered very similarly by respondents. A visual examination of the pattern of responses supports this expectation.

Equity-supportiveness of Organizational Mission

0 = Extremely Unsupportive	3 (2.4%)
1	0
2	2 (1.6%)
3	3 (2.4%)
4	8 (6.5%)
5	10 (8.1%)
6	10 (8.1%)
7	18 (14.5%)
8	26 (21%)
9	20 (16.1%)
10 = Extremely Supportive	19 (15.3%)
Other	5 (4%)

Equity-supportiveness of Organizational Goals

0 = Extremely Unsupportive	1 (0.8%)
1	1 (0.8%)
2	2 (1.6%)
3	3 (2.4%)
4	4 (3.2%)
5	12 (9.7%)
6	14 (11.3%)
7	17 (13.7%)
8	27 (21.8%)
9	21 (16.9%)
10 = Extremely Supportive	18 (14.5%)
Other	4 (3.2%)
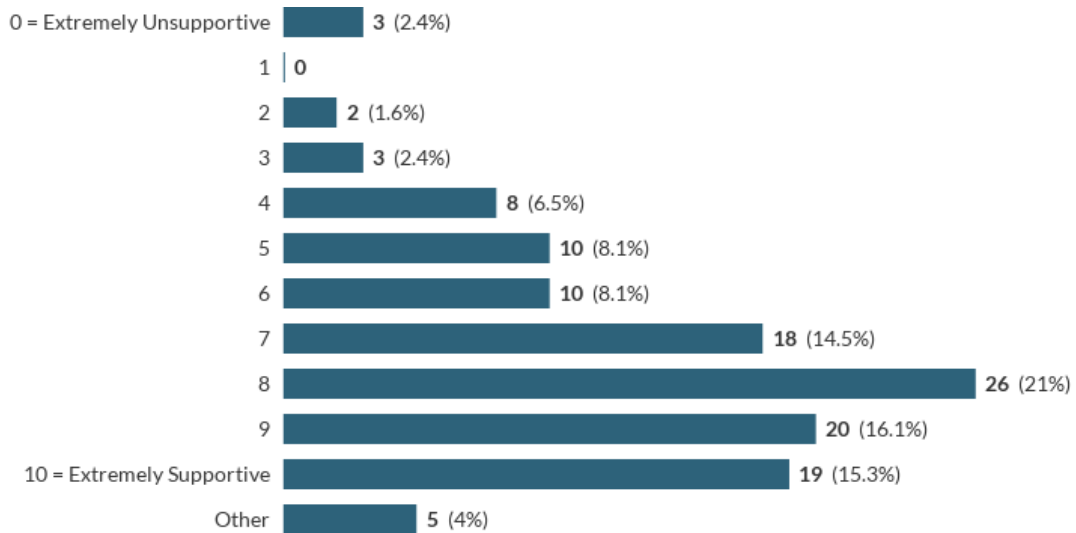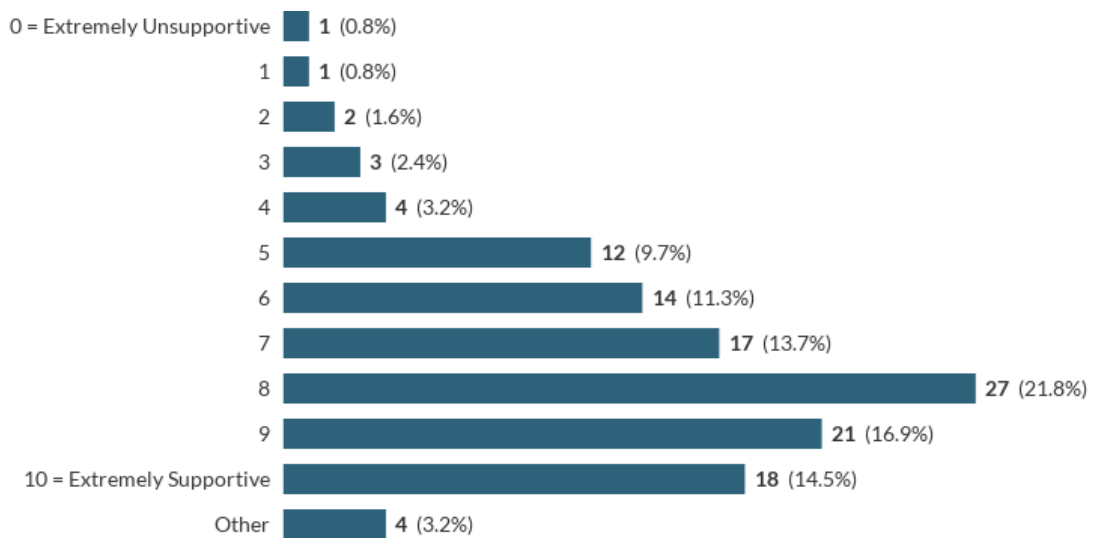
Further, there was high positive correlation between the two variables (r = 0.825) which was also highly significant (p < 0.001), indicating that these variables were collinear. Inclusion of excessively collinear variables in multiple regression models can lead to unstable parameter estimates which are difficult to interpret. Therefore, it was decided to leave out one of these variables, *Organizational Goals*. The correlation between *Organizational Mission* and *Organizational Value*s was r = 0.781 (p < 0.001). Since the r value was less than the threshold value of 0.8 (suggesting overly high correlation), both the variables were retained.

Finally, the following predictor variables were selected for inclusion in the main analysis:

4.7.3.7 Predictor Variables Chosen

1. Type of Organization (NHS or Social Enterprise)

2. Equity-supportiveness of Organizational Mission

3. Equity-supportiveness of Organizational Values

The predictor and outcome variables included in the main analysis (along with the nature of the variable) are summarised in the table below.

Predictor Variables	Outcome Variables
1. Type of Organization (NHS or Social Enterprise) [Categorical variable]	1. Whether the promotion of equity is a formal board responsibility or not [Categorical variable]
2. Equity-supportiveness of Organizational Mission [Continuous variable]	2. Whether a Health Equity Audit (or a similar exercise) is performed for the service or not. [Categorical variable]
3. Equity-supportiveness of Organizational Values [Continuous variable]	3. Whether performance management processes take into consideration the promotion of equity or not. [Categorical variable]
	4. Whether there is a clear assignment of responsibility in the organization for the

	promotion of equity or not. [Categorical variable]
	5. Composite score of importance given by healthcare staff to equity generally in the provision of care and specifically in organizational decision-making (allocation of resources, planning and organization of services). [Continuous variable]

In this section, the predictor variables were screened and the predictor variables that were to be included in the main analysis selected. The reasons for excluding certain predictor variables were stated. In the next section, the overall conceptual model is presented and the steps in the analysis are listed.

4.7.4. Steps in the Statistical Analysis

In this section, the statistical analyses that follow are described.

4.7.4. 1. Conceptual Model

The statistical operations that follow will be concerned to demonstrate the relationships visually summarised in the conceptual model below.

| Type of Organization (NHS or Social Enterprise) | | Equity-supportiveness of Organizational Mission and Values | | Mediating Variables | | Presence of Equity-promoting Organizational Mechanisms | | Mediating Variables | | Importance given by Staff to Equity |
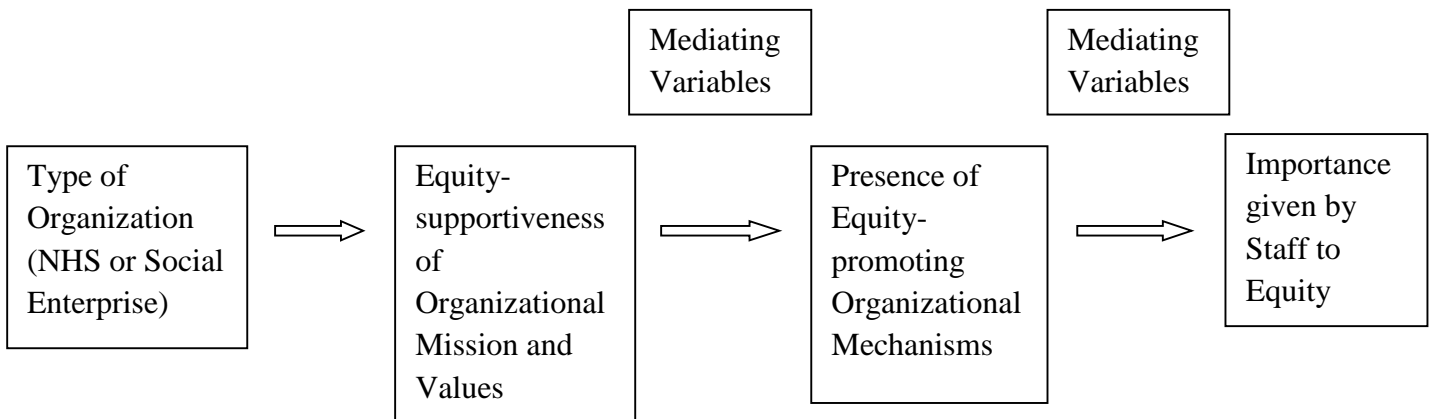
Fig. 4.1 Overall Conceptual Model

The primary research question that this research project tried to address was: are NHS and Social Enterprise organizational cultures equally supportive of equity? In other words, were NHS organizational cultures (cultures of public organizations) more or less supportive of equity than Social Enterprise cultures (cultures of hybrid organizations)?

This question was answered in two ways. Firstly, Independent Samples t-Tests were carried out to compare the equity-supportiveness of various dimensions of NHS and Social Enterprise cultures that matter for the promotion of equity such as their Organizational Mission, Goals, and Values, and the Importance Given to Equity by their Staff Generally and in Organizational Decision-making. The aim of this analysis was to say which of NHS and Social Enterprise cultures rated higher on equity-supportiveness.

Secondly, Pearson's χ^2 Tests for association were carried out to compare the prevalence of equity-promoting organizational mechanisms in the two kinds of organizations. The aim of this analysis was to say which of NHS organizations and Social Enterprises was associated with a greater likelihood of the existence of these specific equity-promoting organizational mechanisms (assuming their equal effectiveness in different contexts). It is suggested that the presence of these equity-promoting organizational mechanisms contributes to the

strengthening of the organization's equity culture, so, the class of organization which evidences a greater likelihood of having these equity-promoting organizational mechanisms is also likely to have a more equity-supportive culture.

The secondary research question that this research project tried to address (and one that was more implicit than explicit) was: how can organizations of all shades (public, private, social enterprise) make healthcare more equitable? *What really matters for equity?* Which organizational practices improve equity? What are the key organizational drivers of equity that have potential for implementation in all types of healthcare provider organizations?

To answer this question, it is worth returning to the conceptual model presented earlier (see below).
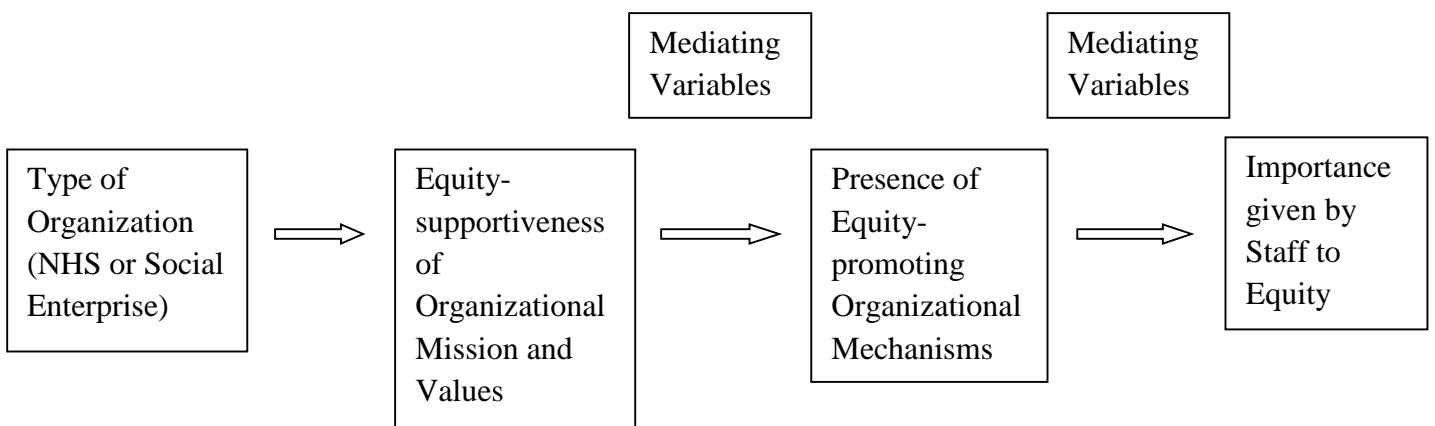
Fig. 4.2 Overall Conceptual Model

It is argued that what truly matters for equity, and what explains differences in organizational equity outcomes, is organizational dynamics, in other words, the systems and processes that organizations have (or do not have) to promote equity. These organizational dynamics include the equity-supportiveness of Organizational Mission and Values and the presence of specific organizational mechanisms that promote equity. If two organizations or two classes of organizations differ in the equity-supportiveness of their Organizational Mission and Values

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and in terms of the presence (or absence) of specific organizational mechanisms that promote equity, they will also, it is argued, differ in terms of how equitably their staff behave towards patients and, consequently, their organizational equity outcomes. The premise underlying this argument is that equity-supportive Organizational Mission and Values may lead to the establishment or strengthening of equity-promoting organizational mechanisms, which, in turn, may result in staff giving more importance to equity (refer to conceptual model above).

Further, it was assumed that the importance that healthcare professionals attached to equity predicted how equitably they behaved towards patients, which, in turn, influenced the equity outcomes of the organization.

Since the degree of importance that healthcare professionals attached to equity was the key predictor of equitable behaviour by them, one of the aims of the statistical analyses was to show that the equity-supportiveness of Organizational Mission and Values and the presence of specific equity-promoting organizational mechanisms determined how much importance healthcare staff attached to equity. Moreover, since the equity-supportiveness of Organizational Mission and Values was the core influence from which the establishment of equity-promoting organizational mechanisms flowed, it was also an aim of the statistical analyses to demonstrate that there was an association between the equity-supportiveness of Organizational Mission and Values and the presence of equity-promoting organizational mechanisms.

To support this argument, it was demonstrated in the statistical analyses that the equity-supportiveness of Organizational Mission and Values and the presence of specific equity-promoting organizational mechanisms predicted the degree of importance given by healthcare staff to equity. To demonstrate this association, linear regressions were carried out a) with the equity-supportiveness of Organizational Mission and Values respectively as predictors, and the Average Importance Given to Equity by Staff as the outcome; and b) with four specific equity-promoting organizational mechanisms respectively as predictors, and the Average Importance Given to Equity by Staff as the outcome [note: the four specific equity-promoting

organizational mechanisms were treated everywhere else in the analysis as outcome variables; however, for the purposes of this particular regression alone, they were treated as predictors].

It was assumed in the analysis that the relationship between the predictors and the outcomes in the model was linear, and that the use of linear regression was, therefore, appropriate. This assumption was made on the grounds that many of the relationships observed in real life are linear, so linearity is often a safe default choice in the absence of evidence to the contrary (there was no evidence from the visual inspection of the relationship between the predictor and outcome variables to suggest that the relationship was non-linear). Further, it was accepted in this analysis that the linearity may be limited to the observed data. It is not suggested that the linearity necessarily extends beyond the limits of the data. Moreover, within the limits of observed data, it is quite common for non-linear functions, such as quadratic functions, to show good approximations to linearity. Therefore, the assumption of linearity was thought to be a reasonable one.

Note: Since the Average Importance Given to Equity by Staff was derived by combining seven different questions (mentioned earlier), as a preliminary step, a Reliability Analysis and a Factor Analysis were carried out to show that the seven questions had a similar underlying structure, were tapping into a single construct, and could be meaningfully combined into a composite score.

Further, it was shown that the equity-supportiveness of Organizational Mission and Values was associated with the relatively greater presence of the four specific equity-promoting organizational mechanisms which were the main outcome variables. As the predictor variables, the equity-supportiveness of Organizational Mission and Values, were continuous variables and the outcome variables were all categorical variables, logistic regressions were carried out with the equity-supportiveness of Organizational Mission and Values respectively as predictors and specific equity-promoting organizational mechanisms as outcomes.

Thus, the steps in the analysis were:

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a) Independent Samples t-Tests for NHS organizations and Social Enterprises (as separate groups) to find out whether there were systematic differences in the equity-supportiveness of various organizational characteristics of NHS organizations and Social Enterprises such as their Organizational Mission, Goals, Values, Ease of Decision-making, Extent of Involvement in Strategic Decision-making, Degree of Autonomy, Importance Given to Equity by Staff, etc. The aim of this analysis was to find out whether public (NHS) organizations differed systematically as a group from hybrid social enterprises in terms of how supportive their organizational mission was of equity, whether decision-making was easier, whether they involved staff in strategic decision-making, etc.

This finding begged the question: if staff in one type of organization consistently gave more importance to equity, why was that so? It was hypothesized that this might be due to the existence of better organizational mechanisms to promote equity in one type of organization. For example, if one class of organization was consistently associated with the presence of more equity-promoting organizational mechanisms, it was likely that that their staff would also give more importance to equity. It seemed reasonable to expect that where these equity-promoting organizational mechanisms were present in a higher degree (and assuming that the mechanisms were equally effective in both kinds of organizational contexts), staff would give more importance to equity. It was assumed here that equity-promoting organizational mechanisms, along with the equity-supportiveness of Organizational Mission and Values, were the principal factors that determined how much importance healthcare staff accorded to equity. To identify whether one class of organization was consistently associated with the presence of more equity-promoting organizational mechanisms, the next analysis was carried out.

b) Categorical Data Analysis using Pearson's χ^2 Tests for association (results summarised descriptively using Odds Ratios). The explanatory variable was Type of Organization (NHS or Social Enterprise). The outcome variables were the 4 equity-promoting organizational mechanisms discussed earlier. The purpose of this analysis was to determine whether 'Type of Organization' was associated with the presence or absence (or relatively greater or lesser presence) of certain equity-promoting organizational mechanisms.

For the remaining three analyses, the overall relationship that is proposed to be demonstrated is presented in the diagram below. This is then followed by a visual depiction of each of the three sub-relationships that are proposed to be demonstrated:

Overall Relationship

Equity-supportiveness of Organizational Mission and Values	$\Longrightarrow$	Presence of Equity-promoting Organizational Mechanisms	$\Longrightarrow$	Importance given by Staff to Equity
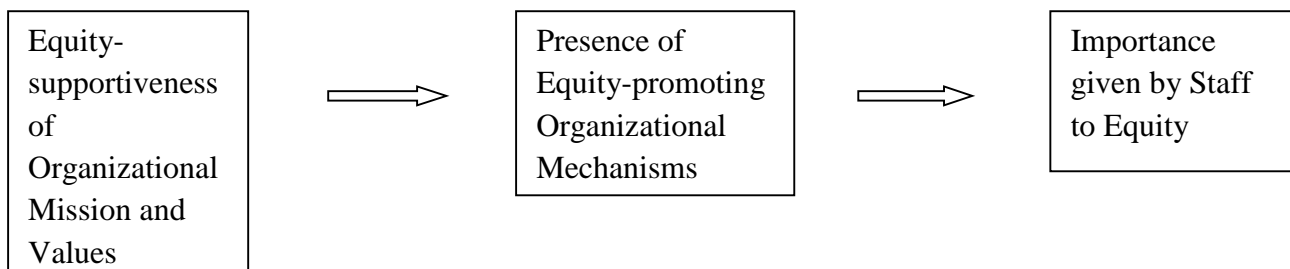
Fig. 4.3 Overall Relationship

c) Sub-relationship 1
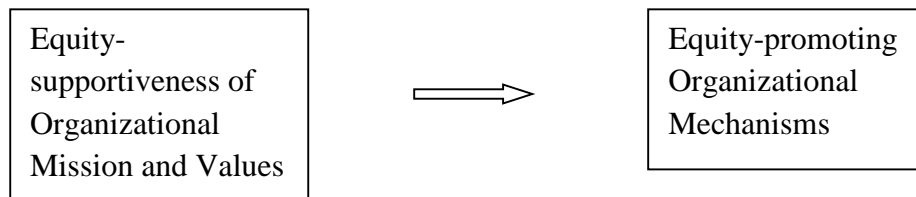
Fig. 4.4 Sub-relationship 1

Modelled with a logistic regression analysis using the equity-supportiveness of Organizational Mission and Values as the predictors and the presence of equity-promoting organizational mechanisms as the outcome.

The presence of effective equity-promoting organizational mechanisms is a key feature of equity-supportive organizational cultures and is a sign that an organization takes equity seriously. Therefore, this empirical demonstration of the relationship between the equity-supportiveness of Organization Mission and Values and the presence of equity-promoting organizational mechanisms suggested that for healthcare provider organizations ensuring that their Organizational Mission and Values were supportive of equity was an important step in creating equity-supportive organizational cultures.

d) Sub-relationship 2
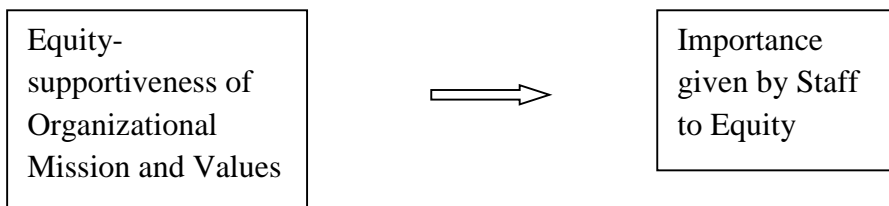
Fig. 4.5 Sub-relationship 2

Modelled with a multiple linear regression analysis using the equity-supportiveness of Organizational Mission and Values as the predictors and the Importance Given to Equity by Staff as the outcome.

In the previous analysis, it was shown that there was a relationship between the equity-supportiveness of Organizational Mission and Values and the presence of equity-promoting organizational mechanisms. In this analysis, it was shown that there was an association between the equity-supportiveness of Organizational Mission and Values and the degree of importance given by staff to equity. Just as the presence of equity-promoting organizational mechanisms may be interpreted as an indicator of *organizational* commitment to promote equity, the degree of importance given by staff to equity may be interpreted as an indicator of *individual* commitment to promote equity. As the equity-supportiveness of Organizational Mission and Values was shown to be related to both the presence of equity-supportive mechanisms and to how much staff valued equity, it is suggested that Organizational Mission and Values are key influences on the equity-supportiveness of organizational cultures. The significance of this finding is followed up later in the *Discussion* section.

e) Sub-relationship 3

```
┌─────────────────┐              ┌─────────────────┐
│ Presence of     │              │ Importance      │
│ Equity-promoting│   ──────▷    │ given by Staff  │
│ Organizational  │              │ to Equity       │
│ Mechanisms      │              │                 │
└─────────────────┘              └─────────────────┘
```
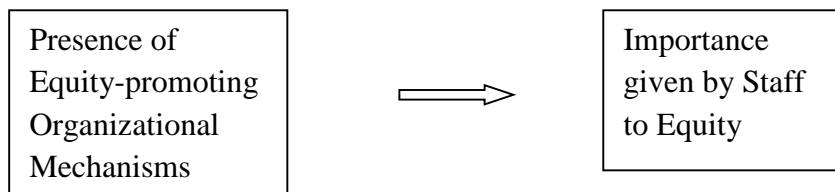
Fig. 4.6 Sub-relationship 3

Modelled with a multiple linear regression analysis using the degree of presence of the four equity-promoting organizational mechanisms as the predictor and the Importance Given to Equity by Staff as the outcome.

In this analysis, the equity-promoting organizational mechanisms that were likely to be particularly salient in influencing how much importance staff gave to equity were identified.

4.8 Literature Search Methodology

Electronic searches of the major medical, social science and business management bibliographic databases were carried out. The following electronic databases were used:

1. General Databases

- Summon
- Google Scholar

2. Medical Databases

- Cochrane Library
- CINAHL (The Cumulative Index to Nursing and Allied Health Literature)
- PubMed (US National Library of Medicine; National Institutes of Health)
- NICE Evidence Search (formerly called NHS Evidence)

3. Social Science Databases

- Scopus
- Web of Science / Knowledge
- ScienceDirect
- PsycInfo
- EThOS (British Library Electronic Theses Online Service)

4. Business / Management Databases

- ABI/INFORM Complete
- Emerald Insight
- Business Source Complete

Search Terms / Keywords

The following is a sampling of the keywords included in the search strategy:

Organizational Culture

Health Equity

Equity Culture

Hybrid organization / Hybridity

Social Enterprise

Community Interest Company

Publicness

New Public Management

Privatisation

Marketisation

Ethical Culture

Organizational Mission

Organizational Values

Leadership

Organizational Effectiveness / Performance

Combinations of Search Terms

Combinations of search terms related to social enterprise, organizational culture and health equity were also employed in the search strategy. A few examples follow.

New Public Management + Health equity

Privatisation + Health Equity

Organizational Culture + Equity

<u>Inclusion and Exclusion Criteria</u>

The titles and abstracts of the articles were screened for potential relevance according to the following criteria. Studies were included if they were:

1. Published in English

2. Contained reputable academic research and scholarship on social enterprise and organizational culture in relation to health equity

Those studies that did not meet the inclusion criteria were excluded. The full texts of the articles that passed the screening were then reviewed in detail.

The approach taken was an inclusive one: case studies, clinical reports, policy documents and discussion/opinion papers were included. This search strategy was applied to all the databases using the appropriate controlled vocabulary.

<u>Other Methods of Sourcing Relevant Academic Literature</u>

The bibliographies of relevant articles were searched to generate more literature. Experts and experienced academics in the field were contacted for advice on further potential studies.

The searches were repeated periodically (every four months) to discover new articles published recently and to update the bibliography with the most recent scholarship in the field.

Chapter 5: Analysis and Results

In this chapter, the analyses and results are presented. As described in the earlier Methodology chapter, this chapter begins with the Independent Samples t-Tests. Next, the Reliability Analysis and Exploratory Factor Analysis (EFA) are described. These are followed by the Pearson's χ^2 Tests for Association. The two Linear Regressions are then presented, followed by the Logistic Regressions for each of the four outcomes.

5.1 Independent Samples t-Tests

This section presents the Independent Samples t-Tests.

5.1.1 Differences between NHS organisations and Social Enterprises in terms of the equity-supportiveness of their Organizational Missions

Levels of equity-supportiveness of their Organizational Mission reported by 54 Social Enterprises (mean = 8.44; SD = 2.22) were 0.41 points higher than those reported by 65 NHS organisations (mean = 8.03; SD = 2.41). No evidence for heterogeneity of variance across

groups was revealed by Levene's test. An independent samples t-test revealed the difference to be non-significant ($t_{117} = -0.966$; $p = 0.336$); 95% CI for difference: (-1.262, 0.435). The effect was small in magnitude ($r = 0.09$).

5.1.2 Differences between NHS organisations and Social Enterprises in terms of the equity-supportiveness of their Organizational Values

Levels of equity-supportiveness of their Organizational Values reported by 56 Social Enterprises (mean = 9.00; SD = 2.27) were 0.67 points higher than those reported by 64 NHS organisations (mean = 8.33; SD = 2.25). No evidence for heterogeneity of variance across groups was revealed by Levene's test. An independent samples t-test revealed the difference to be non-significant ($t_{118} = -1.625$; $p = 0.107$); 95% CI for difference: (-1.49, 0.147). The effect was small in magnitude ($r = 0.02$).

5.1.3 Differences between NHS organisations and Social Enterprises in terms of the Importance Given by their Staff to Equity

Levels of importance given by staff to equity reported by 56 Social Enterprises (mean = 9.30; SD = 1.57) were 0.93 points higher than those reported by 68 NHS organisations (mean = 8.37; SD = 1.85). No evidence for heterogeneity of variance across groups was revealed by Levene's test. An independent samples t-test revealed the difference to be non-significant ($t_{122} = -2.957$; $p = 0.004$); 95% CI for difference: (-1.54, -0.305). The effect was small in magnitude ($r = 0.07$).

5.2 Reliability Analysis

In this section, the Reliability Analysis is described.

A Reliability Analysis was carried out for Qs. 14, 15, 16, 17, 19, 21 and 23. The most widely used measure of reliability is Cronbach's Alpha, for which a value greater than 0.7 is generally considered good (Rattray and Jones, 2007; Moussaoui et al., 2004; Bland and Altman, 1997; Spiliotopoulou, 2009). Cronbach's Alpha for the seven items was 0.919, suggesting that scale reliability as a whole was very high, i.e., the items making up the scale were internally consistent and were measuring the same construct. The reliability of all individual items comprising the scale was also assessed: all scale items were found to make a positive contribution to overall scale reliability and a high degree of correlation was found between the individual items and the overall scale total; supporting the retention of all items in the sub-scale.

In this section, a Reliability Analysis was carried out on the sub-scale. In the next section, the χ^2 Tests that were carried out to check for associations between key variables are reported.

5.3 Pearson's χ^2 Tests for Association

In this section, the χ^2 Tests assessing the strength of evidence for association between organisation type and the presence or absence of equity-promoting organizational mechanisms are presented.

The questions analysed in this section required categorical responses. There were 3 categories of responses: 'Yes', 'No', 'Don't Know'. In the interests of economy of effort and greater accuracy, all the 'Don't Know' responses were re-classified as 'System Missing' so that a 2x2 contingency table with only the 'Yes' and 'No' responses could be obtained. It was expected that this re-classification would not affect the accuracy of the analyses as there was no evidence that the 'Don't know' responses arose from cases which were systematically different from cases providing other responses.

To control the overall Type I error rate (α), Bonferroni's Correction was applied to all tests in this section. As there were four χ^2 Tests, tests were to be conducted at the 0.0125 (0.05/4)

significance level. Expected frequencies in contingency table cells were calculated before conducting the tests to ensure that test assumptions were not violated.

5.3.1 χ^2 Test for Association 1

The specific equity-promoting organizational mechanism being considered in this section was: whether an organization's performance management processes took into consideration the promotion of equity in the provision of care (i.e., whether financial incentives, recognition, etc. were linked to the promotion of equity).

71.1% of Social Enterprise staff reported that their organization had this equity-promoting organizational mechanism whereas 62.8% of NHS staff reported that their organization had this equity-promoting organizational mechanism. Thus, Social Enterprises were more likely than NHS organizations to have this equity-promoting organizational mechanism.

The value of the χ^2 statistic (0.620), which tests for association between categorical variables, was highly non-significant (p = 0.431). Hence, there is no evidence that the Type of Organization (NHS or Social Enterprise) has a statistically significant effect on whether a healthcare provider organization had this specific equity-promoting organizational mechanism.

5.3.2 χ^2 Test for Association 2

The specific equity-promoting organizational mechanism being considered in this section was: whether a Health Equity Audit (or a similar exercise) was performed for the service or not.

72% of Social Enterprise staff reported that their organization had this equity-promoting organizational mechanism whereas 72.7% of NHS staff reported that their organization had this equity-promoting organizational mechanism. Thus, Social Enterprises were slightly less likely than NHS organizations to have this equity-promoting organizational mechanism.

The value of the χ^2 statistic (0.004), which tests for association between categorical variables, was highly non-significant (p = 0.951). Hence, there is no evidence that the Type of Organization (NHS or Social Enterprise) has a statistically significant effect on whether a healthcare provider organization had this specific equity-promoting organizational mechanism.

5.3.3 χ^2 Test for Association 3

The specific equity-promoting organizational mechanism being considered in this section was: whether the promotion of equity in the provision of care was a formal board responsibility or not.

86.2% of Social Enterprise staff reported that their organization had this equity-promoting organizational mechanism whereas 97.3% of NHS staff reported that their organization had this equity-promoting organizational mechanism. Thus, Social Enterprises were less likely than NHS organizations to have this equity-promoting organizational mechanism.

The value of the χ^2 statistic (2.856), which tests for association between categorical variables, was non-significant (p = 0.091). Hence, there is no evidence at the 5% significance level that the Type of Organization (NHS or Social Enterprise) has a statistically significant effect on whether a healthcare provider organization had this specific equity-promoting organizational mechanism. However, the test statistic may be indicative of a substantive relationship.

5.3.4 χ^2 Test for Association 4

The specific equity-promoting organizational mechanism being considered in this section was: whether there was a clear assignment of responsibility in the organization for the promotion of equity or not.

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92.5% of Social Enterprise staff reported that their organization had this equity-promoting organizational mechanism whereas 86% of NHS staff reported that their organization had this equity-promoting organizational mechanism. Thus, Social Enterprises were more likely than NHS organizations to have this equity-promoting organizational mechanism.

The value of the χ^2 statistic (0.951), which tests for association between categorical variables, was highly non-significant (p = 0.33). Hence, there is no evidence that the Type of Organization (NHS or Social Enterprise) has a statistically significant effect on whether a healthcare provider organization had this specific equity-promoting organizational mechanism.

5.3.5 Summary

A summary of the results is reported below.

1. Do [internal] performance management processes take into consideration the promotion of equity in the provision of care (i.e., are financial incentives, recognition, etc. linked to the promotion of equity)?

Social Enterprises slightly more likely (71% > 63%) but difference not statistically significant

2. Is a Health Equity Audit (or a similar exercise) performed for your unit / service?

NHS slightly more likely (73% > 72%) but difference not statistically significant

3. Is the promotion of equity in the provision of care a formal board responsibility?

NHS slightly more likely (97% > 86%); the difference is not statistically significant at the 5% significance level, however, the result may indicate the presence of an effect of some substantive importance.

4. Is there a clear assignment of responsibility in the organization for the promotion of equity in the provision of care?

Social Enterprises slightly more likely (92.5% > 86%) but difference not statistically significant.

The overall picture that emerged was that NHS organizations and Social Enterprises were evenly balanced in terms of the presence of equity-promoting organizational mechanisms.

5.4 Linear Regression 1

In this section, a series of Linear Regression analyses are presented, considering the outcome variable *The Average Importance Given to Equity by Staff*. Three analyses are reported. The first two are Linear Regressions involving one predictor and one outcome. These regressions were uncontrolled regressions and were used as a screening tool to select predictor variables for entry into the multiple regression model. The third is a Multiple Linear Regression with two predictors (which passed the screening) and one outcome variable.

The assumption of linearity in all analyses was tested through visual inspection of the data. No evidence for obvious non-linear trends (e.g. curvilinear relationships) was observed within the limits of the observed data. Correlations between predictor variables were also

assessed in the multiple regression analysis, finding no evidence for collinearity between variables.

5.4.1 Multiple Linear Regression with One Predictor and One Outcome

The equity-supportiveness of a healthcare provider organization's Organizational Mission was the predictor variable.

The outcome variable was the Average Importance Given to Equity by Staff.

119 cases who provided valid scores for both the predictor and outcomes variables were included in the analysis. The mean predictor score was 8.22 (SD 2.33). The mean outcome score, based on the included cases, was 8.83 (SD 1.77).
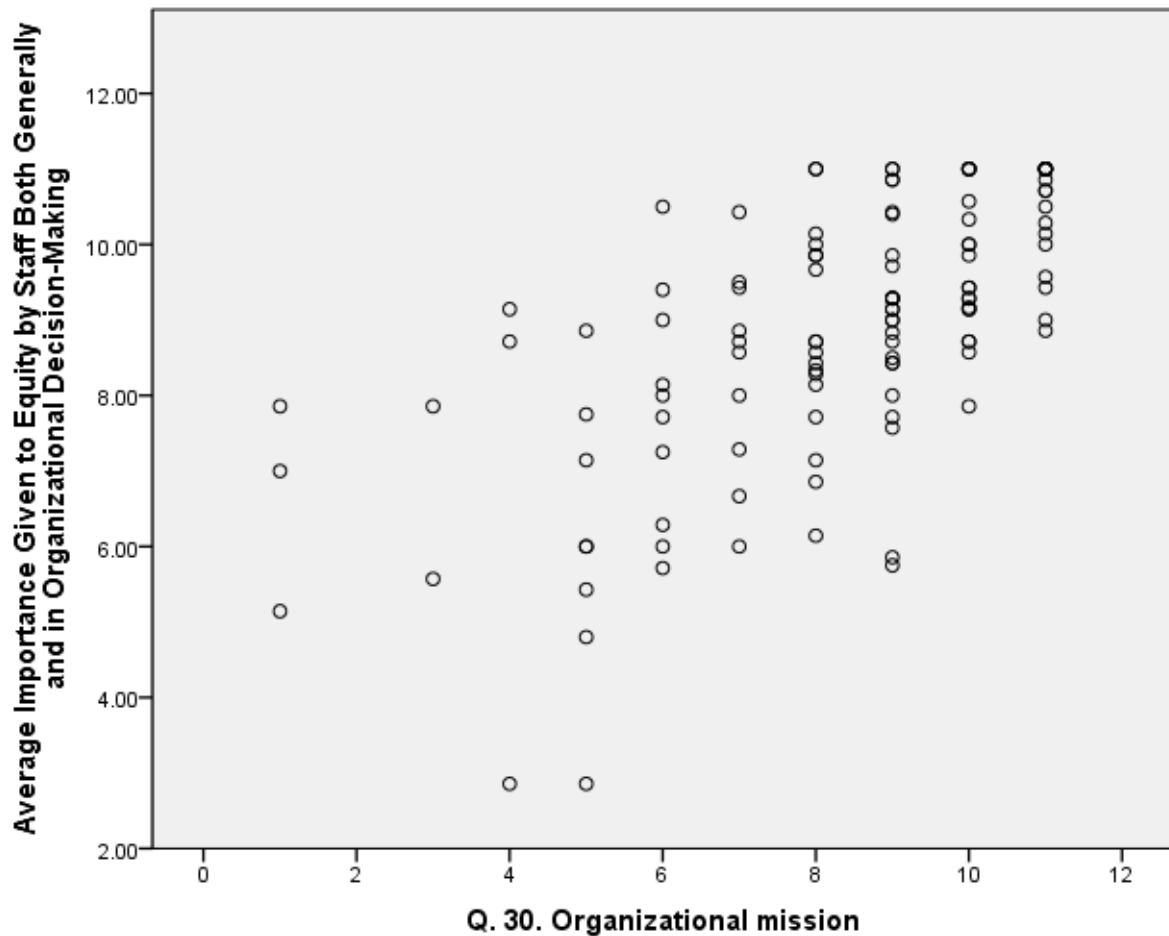
Interpreting the Linear Regression Output

The regression coefficient for the predictor variable *Equity-supportiveness of Organizational Mission* was 0.488 (95% CI (0.381, 0.594); p < 0.001), which was a highly significant predictor of the outcome. The R^2 value for the model was 0.412; hence, the predictor accounted for 41.2% of model variance.

Coefficients[a]

Model	Unstandardized Coefficients		Standardized Coefficients	t	Sig.	95.0% Confidence Interval for B		Correlations			Collinearity Statistics	
	B	Std. Error	Beta			Lower Bound	Upper Bound	Zero-order	Partial	Part	Tolerance	VIF

| 1 | (Constant) | 4.816 | .460 | | 10.480 | .000 | 3.906 | 5.726 | | | | | |
| | Q. 30. Organizational mission | .488 | .054 | .642 | 9.057 | .000 | .381 | .594 | .642 | .642 | .642 | 1.000 | 1.000 |

a. Dependent Variable: Average Importance Given to Equity by Staff Both Generally and in Organizational Decision-Making

Thus, the overall conclusion was that the predictor variable 'Equity-supportiveness of Organizational Mission' (on its own, without controlling for the effects of other predictor variables such as the 'Equity-supportiveness of Organizational Values') was a significant predictor of the outcome variable 'Average Importance Given to Equity by Staff'.

5.5.2 Multiple Linear Regression with One Predictor and One Outcome

The equity-supportiveness of a healthcare provider organization's Organizational Values was the predictor variable.

The outcome variable was the Average Importance Given to Equity by Staff.

120 cases who provided valid scores for both the predictor and outcomes variables were included in the analysis. The mean predictor score was 8.64 (SD 2.27). The mean outcome score, based on the included cases, was 8.88 (SD 1.70).

Interpreting the Linear Regression Output

The regression coefficient for the predictor variable *Equity-supportiveness of Organizational Values* was 0.412 (95% CI (0.298, 0.526); $p<0.001$), which was a highly significant predictor of the outcome. The R^2 value for the model was 0.302; hence the predictor accounted for 30.2% of model variance.
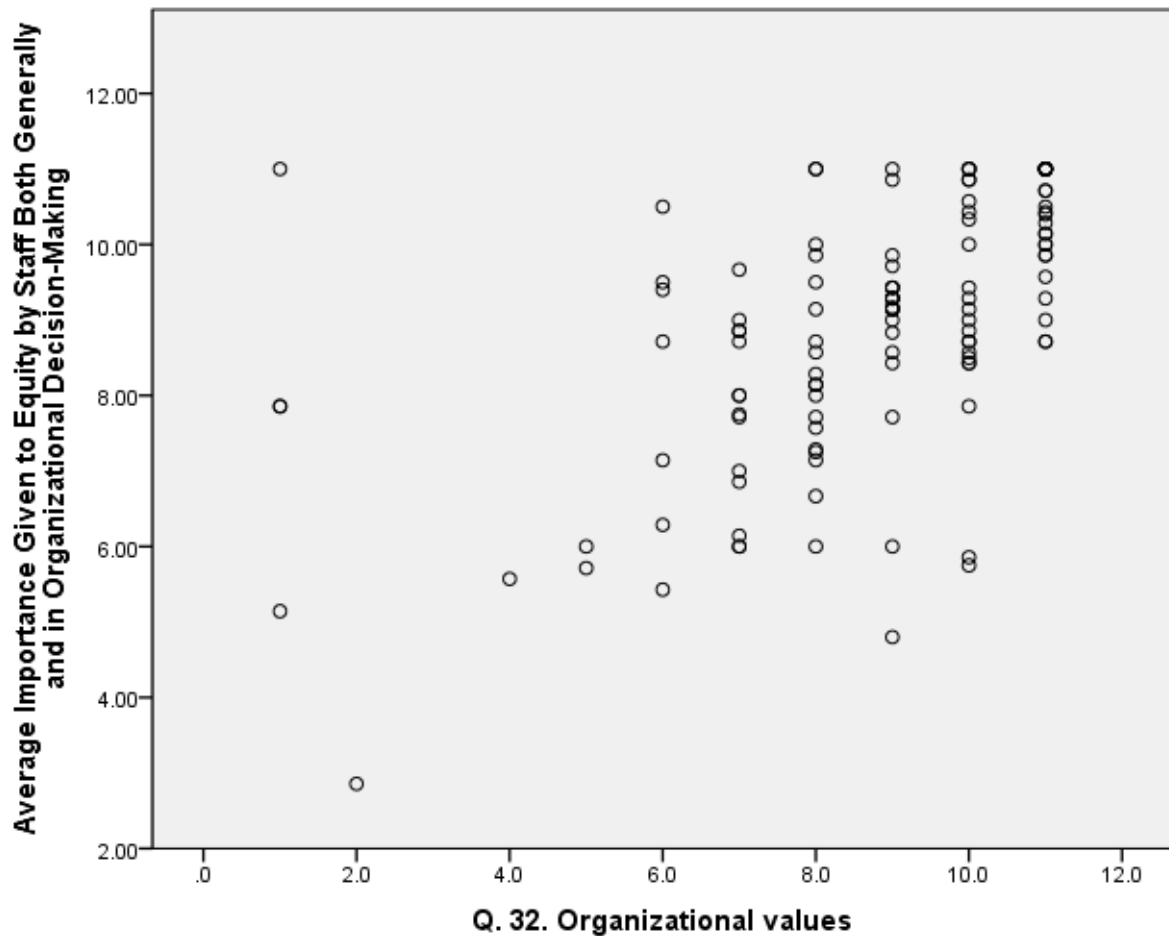
Thus, the overall conclusion was that the predictor variable 'Equity-supportiveness of Organizational Values' (on its own, without controlling for the effects of other predictor variables such as the 'Equity-supportiveness of Organizational Mission') was a significant predictor of the outcome variable 'Average Importance Given to Equity by Staff'.

Hence, both predictors were highly significant in univariable models and were carried forward for inclusion in a multiple model.

5.4.3 Multiple Linear Regression with Two Predictors and One Outcome

The equity-supportiveness of a healthcare provider organization's Organizational Mission and Organizational Values were the two predictor variables in this analysis.

The outcome variable was the Average Importance Given to Equity by Staff.

A backward elimination modelling strategy was used for the multiple model because the analysis was a kind of exploratory model-building and the relative importance of the predictor variables was not known in advance. Therefore, a sequential modelling strategy was not suitable.

117 cases who provided valid scores for both predictor variables, and the outcomes variables were included in the analysis. The mean predictor score for the predictor variable *Equity-supportiveness of Organizational Mission* was 8.25 (SD 2.33). The mean predictor score for the predictor variable *Equity-supportiveness of Organizational Values* was 8.71 (SD 2.19). The mean outcome score, based on the included cases, was 8.88 (SD 1.69).

Interpreting the Multiple Linear Regression Output

Both predictor variables Equity-supportiveness of Organizational Mission (p = 0.001; parameter estimate 0.273, 95% CI (0.113, 0.433)) and Equity-supportiveness of Organizational Values (p = 0.003, parameter estimate 0.261, 95% CI (0.091, 0.431)) were highly significant predictors of the outcome.

Hence, it is concluded that positive relationships exist between each predictor variable and the outcome, controlling for the other predictor variable.

Standardized parameter coefficients suggested that the Equity-supportiveness of Organizational Mission was a slightly more important predictor (Standardized Beta Coefficient = 0.375) than the Equity-supportiveness of Organizational Values (Standardized Beta Coefficient = 0.338).

Regression Diagnostics

Inspection of standardised residuals for the multiple model (Casewise Diagnostics table below) revealed 6 cases with standardised residuals with absolute value > 2.0; and 3 cases with standardised residuals with absolute value > 2.5. This is within expectations for a data set of this size and has no implications for parameter estimates. The maximum value of Cook's Distance (Cook and Weisberg, 1982) for this dataset was 0.281, indicating that no case was exerting an undue influence on the model.

Casewise Diagnostics[a]

Case Number	Std. Residual	Average Importance Given to Equity by Staff Both Generally and in Organizational Decision-Making	Predicted Value	Residual
10	-2.908	5.75	9.4200	-3.67000
12	-2.465	2.86	5.9684	-3.11126
27	2.352	7.86	4.8890	2.96818
30	-2.589	4.80	8.0677	-3.26773
58	-2.823	5.86	9.4200	-3.56286
88	2.331	10.50	7.5578	2.94221

a. Dependent Variable: Average Importance Given to Equity by Staff Both Generally and in Organizational Decision-Making

The Scatterplot (below) of the Standardized Residuals plotted against the Standardized Predicted Values gave an indication of whether the assumptions of the model had been met. There was a suggestion of funnelling in the graph, indicating possible heteroscedasticity. However, this was not particularly noticeable suggesting that any possible heteroscedasticity was likely to be small, if at all. The assumption of linearity appeared to have been met as there was no discernible curve in the graph.

Scatterplot

Dependent Variable: Average Importance Given to Equity by Staff Both Generally and in Organizational Decision-Making
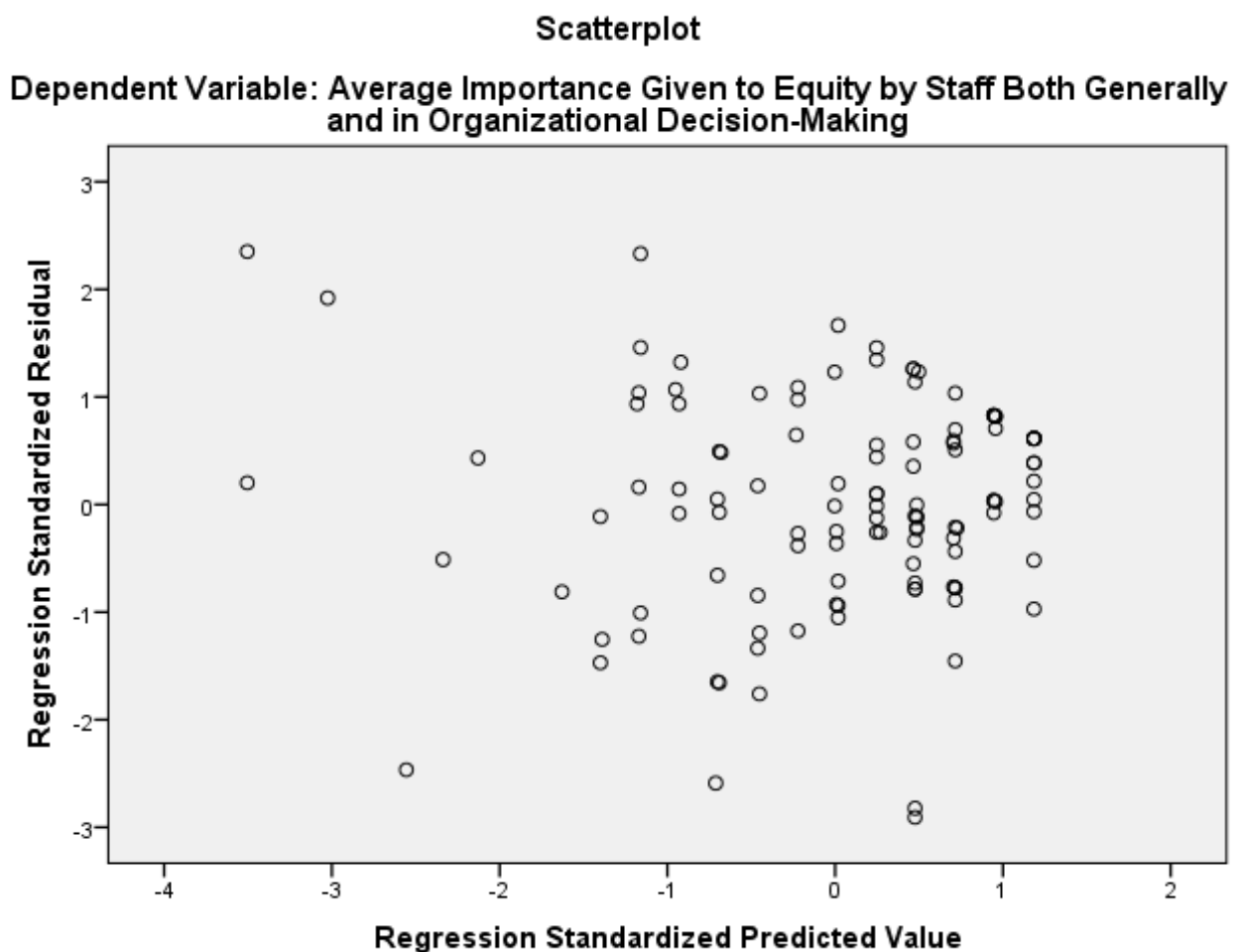
The histogram below suggested normality of the residuals. The distribution was roughly normal, although there was a slightly greater concentration of values towards the positive end of the distribution. Thus, the data seemed to show very slight deviation from normality. However, there appeared to be no real cause for concern.

Histogram

Dependent Variable: Average Importance Given to Equity by Staff Both Generally and in Organizational Decision-Making
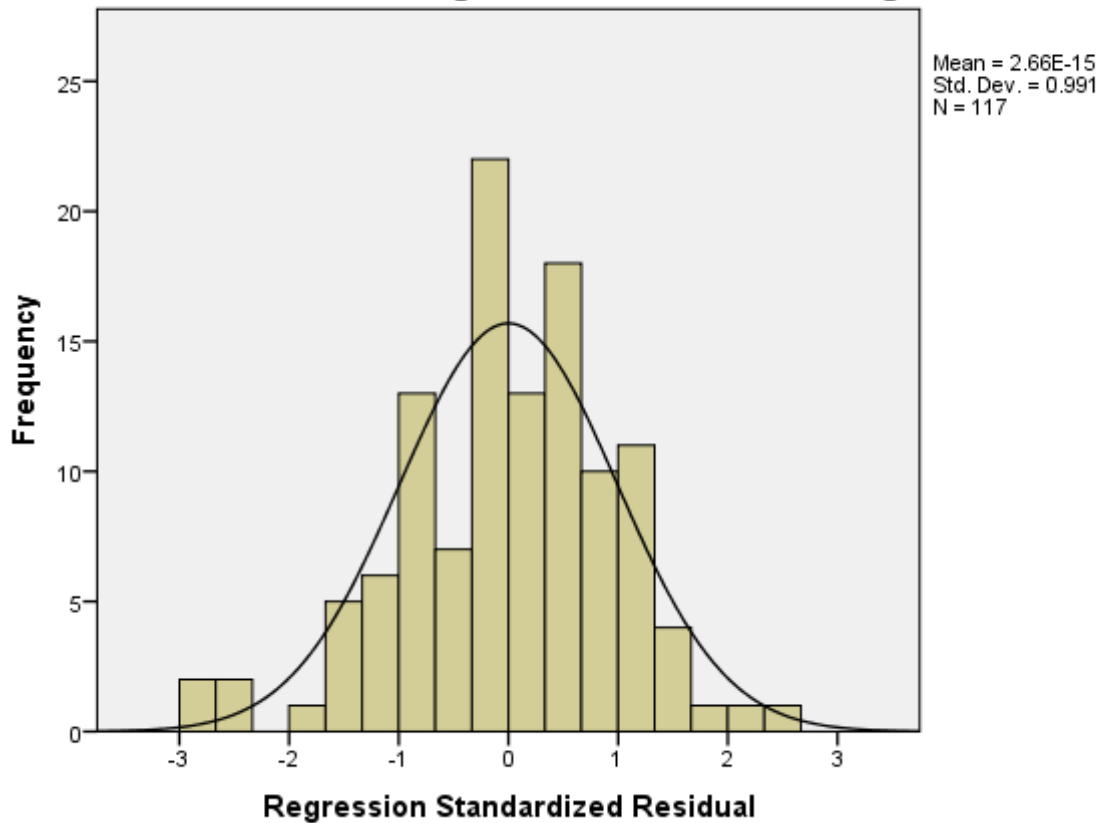
The overall conclusion that was drawn from the diagnostic statistics was that the model was both accurate for the sample and generalizable to the population. On the whole, the assumptions appeared to have been met, and the model appeared not only to be valid for the sample, but was also generalizable beyond the sample.

Conclusion

Using regression, the Equity-supportiveness of Organization Mission and the Equity-supportiveness of Organization Values were identified from all the possible variables as the

best predictors of 'Importance given to Equity by Staff'. The regression analyses suggested that the Equity-supportiveness of Organizational Mission was the most significant predictor, followed by the Equity-supportiveness of Organizational Values.

5.5 Linear Regression 2

In this section, five analyses are reported. The first four are Linear Regressions involving one predictor and one outcome. These regressions were uncontrolled regressions and were used as a screening tool to select predictor variables for entry into the multiple regression model. The fifth is a Multiple Linear Regression with two predictors (which passed the screening) and one outcome variable.

The predictor variables in this analysis were categorical variables indicating the presence or absence of an equity-promoting organizational mechanism. The four equity-promoting mechanisms were:

a) Whether the promotion of equity in the provision of care was a formal board responsibility or not.

b) Whether Health Equity Audits (or similar exercises) were performed for the service or not.

c) Whether performance management processes took into consideration the promotion of equity (i.e., whether financial incentives, recognition, etc. were linked to the promotion of equity) or not.

d) Whether there was a clear assignment of responsibility in the organization for the promotion of equity or not.

The predictor variable for this analysis was a categorical variable: whether the promotion of equity in the provision of care was a formal board responsibility or not.

The outcome variable was the Average Importance Given to Equity by Staff.

66 cases who provided valid scores for both the predictor and outcomes variables were included in the analysis. The mean predictor score was 1.92 (SD 0.27). The mean outcome score, based on the included cases, was 9.11 (SD 1.48).

Interpreting the Linear Regression Output

From the 'Model Summary' table, it was noted that the value of R^2 for the regression model was approximately 0.000 (thus, the model accounted for approximately 0% of the variance in the outcome). The R^2 Change statistic ($p = 0.892$) was non-significant suggesting that the addition of this predictor to the model did not increase its predictive power.

Further analyses such as the ANOVA and the estimate for the regression coefficient confirmed the result arrived at above that the predictor variable showed no substantive association with the outcome variable. Subsequent analyses are, therefore, not reported.

Thus, the overall conclusion was that the predictor variable 'Whether the promotion of equity in the provision of care was a formal board responsibility or not' (on its own, without controlling for the effects of other predictor variables) did not predict the outcome variable 'Average Importance Given to Equity by Staff'.

5.5.2 Multiple Linear Regression with One Predictor and One Outcome

The predictor variable for this analysis was a categorical variable: whether Health Equity Audits (or similar exercises) were performed for the service or not.

The outcome variable was the Average Importance Given to Equity by Staff.

58 cases who provided valid scores for both the predictor and outcomes variables were included in the analysis. The mean predictor score was 1.72 (SD 0.45). The mean outcome score, based on the included cases, was 8.71 (SD 1.96).

Interpreting the Linear Regression Output

From the 'Model Summary' below, it was noted that the value of R^2 for the regression model was 0.049 (thus, the model accounted for 4.9% of the variance in the outcome). The R^2 Change statistic (p = 0.095) was non-significant suggesting that the addition of this predictor to the model did not increase its predictive power.

Thus, the overall conclusion was that the predictor variable 'Whether Health Equity Audits (or similar exercises) were performed for the service or not' (on its own, without controlling for the effects of other predictor variables) did not predict the outcome variable 'Average Importance Given to Equity by Staff'.

5.5.3 Multiple Linear Regression with One Predictor and One Outcome

The predictor variable for this analysis was a categorical variable: whether there was a clear assignment of responsibility in the organization for the promotion of equity or not.

The outcome variable was the Average Importance Given to Equity by Staff.

90 cases who provided valid scores for both the predictor and outcomes variables were included in the analysis. The mean predictor score was 1.89 (SD 0.32). The mean outcome score, based on the included cases, was 9.10 (SD 1.54).

Interpreting the Linear Regression Output

From the 'Model Summary' table, it was noted that the value of R^2 for the regression model was 0.245 (thus, the model accounted for 24.5% of the variance in the outcome). The difference between R^2 and Adjusted R^2 for the model was very small (0.009 or 0.9%), indicating that the cross-validity of the final model was good. The significant R^2 Change statistic ($p < 0.001$) suggested that the addition of the predictor to the model increased its predictive power.

The predictor variable ($p < 0.001$, 95% CI (1.517, 3.316)) was a highly significant predictor of the outcome. A positive regression coefficient of 2.417 suggested that there was a positive relationship between the predictor and outcome variables.

Thus, the overall conclusion was that the predictor variable 'Whether there was a clear assignment of responsibility in the healthcare provider organization for the promotion of equity or not' (on its own, without controlling for the effects of other predictor variables) was a significant predictor of the outcome variable 'Average Importance Given to Equity by Staff'.

5.5.4 Multiple Linear Regression with One Predictor and One Outcome

The predictor variable for this analysis was a categorical variable: whether performance management processes took into consideration the promotion of equity (i.e., whether financial incentives, recognition, etc. were linked to the promotion of equity) or not.

The outcome variable was the Average Importance Given to Equity by Staff.

81 cases who provided valid scores for both the predictor and outcomes variables were included in the analysis. The mean predictor score was 1.67 (SD 0.47). The mean outcome score, based on the included cases, was 8.80 (SD 1.89).

Interpreting the Linear Regression Output

From the 'Model Summary' table, it was noted that the value of R^2 for the regression model was 0.350 (thus, the model accounted for 35% of the variance in the outcome). The difference between R^2 and Adjusted R^2 for the model was very small (0.008 or 0.8) indicating that the cross-validity of the final model was good. The significant R^2 Change statistic ($p < 0.001$) suggested that the addition of the predictor to the model increased its predictive power.

The estimate for the regression coefficient (*b-value*) was observed from the 'Coefficients' table below. The predictor variable ($p < 0.001$, 95% CI (1.634, 3.069)) was a highly significant predictor of the outcome. A positive regression coefficient of 2.352 suggested that there was a positive relationship between the predictor and outcome variables.

Thus, the overall conclusion was that the predictor variable 'Whether performance management processes took into consideration the promotion of equity (i.e., whether financial incentives, recognition, etc. were linked to the promotion of equity) or not' (on its own, without controlling for the effects of other predictor variables) was a significant predictor of the outcome variable 'Average Importance Given to Equity by Staff'.

5.5.5 Multiple Linear Regression with Two Predictors and One Outcome

As reported above, two of the four possible predictor variables turned out to be highly significant predictors of the outcome on their own (when the other variables were not being controlled for). Therefore, using the preceding regression models as a screening process, these two predictors were included in the final regression model.

The two predictor variables in this analysis were (the following categorical variables):

1. Whether the healthcare provider organization's performance management processes took account of equity or not (abbreviated to *Equity Performance Management Processes*). The two possible responsible categories were: a) Yes, they did, and b) No, they did not.

2. Whether there was a clear assignment of responsibility in the healthcare provider organization for the promotion of equity or not (abbreviated to *Clear Assignment of Responsibility for Equity*). The two possible responsible categories were: a) Yes, there was, and b) No, there was not.

The outcome variable was the *Average Importance Given to Equity by Staff*.

66 cases who provided valid scores for both predictor variables, and the outcomes variables were included in the analysis. The mean predictor score for the predictor variable *Equity Performance Management Processes* was 1.71 (SD 0.46). The mean predictor score for the predictor variable *Clear Assignment of Responsibility for Equity* was 1.86 (SD 0.35). The mean outcome score, based on the included cases, was 9.21 (SD 1.59).

A backward elimination modelling strategy was used for the multiple model because the analysis was a kind of exploratory model-building and the relative importance of the predictor variables was not known in advance. Therefore, a sequential modelling strategy was not suitable.

From the 'Model Summary' table, it was noted that the value of R^2 for the regression model was 0.468 (thus, the model accounted for 46.8% of the variance in the outcome). The difference between R^2 and Adjusted R^2 for the model was very small (0.017 or 1.7 %), indicating that the cross-validity of the final model was good. The significant R^2 Change statistic ($p < 0.001$) suggested that the addition of the two predictors to the model increased its predictive power.

Both predictor variables *Equity Performance Management Processes* ($p = 0.003$; 95% CI (0.443, 2.084)) and *Clear Assignment of Responsibility for Equity* ($p = 0.001$; 95% CI (0.741, 2.905)) were highly significant predictors of the outcome.

A positive regression coefficient of 1.264 for the predictor variable *Equity Performance Management Processes* suggested that there was a positive relationship between it and the outcome variable *Average Importance Given to Equity by Staff*, while controlling for the other predictor variable *Clear Assignment of Responsibility for Equity.*

The positive regression coefficient of 1.823 for the predictor variable *Clear Assignment of Responsibility for Equit*y suggested that there was also a positive relationship between it and the outcome variable *Average Importance Given to Equity by Staff*, while controlling for the other predictor variable *Equity Performance Management Processes*.

Hence, it is concluded that positive relationships exist between each predictor variable and the outcome, controlling for the other predictor variable.

Standardized parameter coefficients suggested that the *Clear Assignment of Responsibility for Equity* was a slightly more important predictor (Standardized Beta Coefficient = 0.396) than *Equity Performance Management Processes* (Standardized Beta Coefficient = 0.362).

Regression Diagnostics

Inspection of standardised residuals for the multiple model (Casewise Diagnostics below) revealed 3 cases with standardised residuals with absolute value > 2.0; and 1 case with standardised residuals with absolute value > 2.5. This is within expectations for a data set of this size and have no implications for parameter estimates. The maximum value of Cook's Distance (Cook and Weisberg, 1982) for this dataset was 0.507, indicating that no case was exerting an undue influence on the model.

Casewise Diagnostics[a]

Case Number	Std. Residual	Average Importance Given to Equity by Staff Both Generally and in Organizational Decision-Making	Predicted Value	Residual
12	-3.289	2.86	6.7341	-3.87698
15	-2.412	5.71	8.5571	-2.84286
110	2.044	9.14	6.7341	2.40873

a. Dependent Variable: Average Importance Given to Equity by Staff Both Generally and in Organizational Decision-Making

The histogram (below) suggested that the distribution was approximately normal, although the data did seem to show a slight deviation from normality. However, perfectly normal distributions are rare in the real world, and the departure from normality was not so significant as to cause concern.

Histogram

Dependent Variable: Average Importance Given to Equity by Staff Both Generally and in Organizational Decision-Making

Mean = 1.44E-15
Std. Dev. = 0.984
N = 66
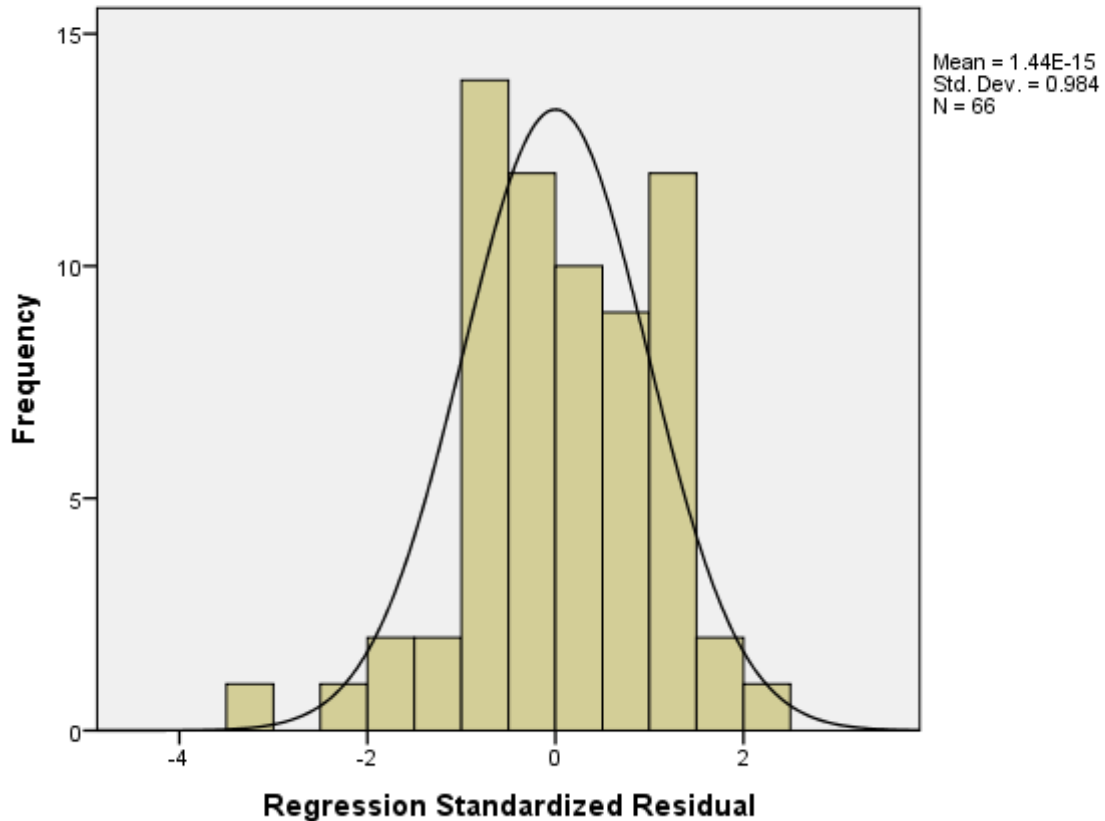
The overall conclusion that was drawn from the diagnostic statistics was that the model was both accurate for the sample and generalizable to the population. On the whole, the assumptions appeared to have been met, and the model appeared not only to be valid for the sample, but was also generalizable beyond the sample.

Conclusion:

Regression analyses were used to identify which of the four equity-promoting organizational mechanisms were the best predictors of 'Importance given to Equity by Staff'. The regression analyses suggested that after controlling for other variables 'Clear Assignment of

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Responsibility for Equity' was the most significant predictor, followed by 'Equity Performance Management Processes'.

5.6 Logistic Regression

This section describes the Logistic Regressions for each of the four categorical outcome variables (equity-promoting organizational mechanisms).

5.6.1 Binary Logistic Regression - Outcome 1

In this section, three analyses are reported. The first two are Binary Logistic Regressions involving one predictor and one outcome. These regressions were uncontrolled regressions and were used as a screening tool to select predictor variables for entry into the multiple regression model. The third is a Multiple Binary Logistic Regression with two predictors (which passed the screening) and one outcome variable.

In all models, the significance of the predictor was assessed by the corresponding change in likelihood ratio statistic (ΔLRS) between a null (i.e. constant only) model and a model with the predictor. This statistic approximately follows a χ^2 distribution with one degree of freedom.

5.6.1.1 Binary Logistic Regression with One Predictor (Equity-supportiveness of Organizational Mission) and One Outcome

The equity-supportiveness of a healthcare provider organization's Organizational Mission was the predictor variable.

The outcome variable was the presence or absence of an equity-promoting organizational mechanism. The specific equity-promoting organizational mechanism being considered was: whether the healthcare provider organization's performance management processes took account of equity or not. The two possible responsible categories were: a) Yes, they did, and b) No, they did not.

Testing assumptions

The linearity of the relationship between continuous predictors and the transformed outcomes was tested by assessing the interaction between each predictor variable and the natural logarithm (ln) of that predictor variable, with violation of the linearity assumption indicated by a significant interaction term (Hosmer & Lemeshow, 1989). No violations of the linearity assumption were detected in any models. Any models with 2 or more predictor variables were also subjected to checks for collinearity.

Interpreting the Logistic Regression Output

A model including the predictor variable *Equity-supportiveness of Organizational Mission* was a better fit to the data than a constant-only model, as measured by the ΔLRS of 25.7, which was statistically significant ($p < 0.001$).

The 'Nagelkerke pseudo-R^2' statistic of 0.384 suggested a well-fitting model.

The null model correctly classified 65.8% of the responses. The 'Classification Table' for the new model (below) correctly predicted 75.9% of the responses. So, the predictive ability of the new model was notably greater than that of the baseline model.

Classification Table[a]

			Predicted		
			Recoded Q. 2. Do performance management processes take into consideration the promotion of equity in the provision of care (i.e., are financial incentives, recognition, etc. linked to the promotion of equity)?		Percentage
	Observed		No	Yes	Correct
Step 1	Recoded Q. 2. Do performance management processes take into consideration the promotion of equity in the provision of care (i.e., are financial incentives, recognition, etc. linked to the promotion of equity)?	No	15	12	55.6
		Yes	7	45	86.5
	Overall Percentage				75.9

a. The cut value is .500

The odds ratio of 1.88 for the predictor variable indicated that as the predictor variable increased by one unit, the predicted odds of the outcome increased by 88% at best estimate. Thus, as the Equity-supportiveness of Organizational Mission increased, the odds of the presence of the specific equity-promoting mechanism in question increased, too.

Thus, the overall conclusion was that the predictor variable *Equity-supportiveness of Organizational Mission* (on its own, without controlling for the effects of the other predictor variable *Equity-supportiveness of Organizational Values*) was a significant predictor of the outcome variable *Whether performance management processes took account of equity or not*.

5.6.1.2 Binary Logistic Regression with One Predictor (Equity-supportiveness of Organizational Values) and One Outcome

The equity-supportiveness of a healthcare provider organization's Organizational Values was the predictor variable.

The outcome variable was the presence or absence of an equity-promoting organizational mechanism. The specific equity-promoting organizational mechanism being considered in was: whether the healthcare provider organization's performance management processes took account of equity or not. The two possible responsible categories were: a) Yes, they did, and b) No, they did not.

Interpreting the Logistic Regression Output

A model including the predictor variable *Equity-supportiveness of Organizational Values* was a better fit to the data than a constant-only model, as measured by the ΔLRS of 14.02, which was statistically significant (p < 0.001).

The 'Nagelkerke pseudo-R^2' statistic of 0.228 suggested a well-fitting model.

The null model correctly classified 66.7% of the responses. The 'Classification Table' (below) for the new model correctly predicted 74.4% of the responses. So, the predictive ability of the new model was notably greater than that of the baseline model.

Classification Table[a]

			Predicted		
			Recoded Q. 2. Do performance management processes take into consideration the promotion of equity in the provision of care (i.e., are financial incentives, recognition, etc. linked to the promotion of equity)?		Percentage
	Observed		No	Yes	Correct
Step 1	Recoded Q. 2. Do performance management processes take into consideration the promotion of equity in the provision of care (i.e., are financial incentives, recognition, etc. linked to the promotion of equity)?	No	11	15	42.3
		Yes	5	47	90.4
	Overall Percentage				74.4

a. The cut value is .500

The odds ratio of 1.59 for the predictor variable indicated that as the predictor variable increased by one unit, the predicted odds of the outcome increased by 59% at best estimate. Thus, as the Equity-supportiveness of Organizational Values increased, the odds of the presence of the specific equity-promoting mechanism in question increased, too.

Thus, the overall conclusion was that the predictor variable *Equity-supportiveness of Organizational Values* (on its own, without controlling for the effects of the other predictor

variable *Equity-supportiveness of Organizational Mission*) was a significant predictor of the outcome variable *Whether performance management processes took account of equity or not*.

5.6.1.3 Multiple Binary Logistic Regression with Two Predictors and One Outcome

As reported above, both the predictor variables turned out to be highly significant predictors of the outcome on their own (when the other variable was not being controlled for). Therefore, using the preceding regression models as a screening process, both these predictors were included in a multiple regression model.

An interaction term between the predictors was not included because it did not seem meaningful in practical terms.

The outcome variable was the presence or absence of an equity-promoting organizational mechanism. The specific equity-promoting organizational mechanism being considered was: whether the healthcare provider organization's performance management processes took account of equity or not. The two possible responsible categories were: a) Yes, they did, and b) No, they did not.

A backward elimination modelling strategy based on the Likelihood Ratio (LR) method was used for the multiple model because the analysis was a kind of exploratory model-building and the relative importance of the predictor variables was not known in advance. Therefore, a sequential modelling strategy was not suitable. Using this strategy, a final model was derived including only *Equity-supportiveness of Organizational Mission* as a predictor. Hence the model characteristics of the final model were as presented in section 5.6.1.1.

Regression Diagnostics

One case was found to have a Normalised residual of 3.5; slightly above expectations for a data set of this size. However, absolute values of DFBETA statistics, leverage values and analogs of Cook's Influence Statistics were within expectations for all cases, indicating that no individual case was exerting undue influence on model parameters.

The conclusion that was drawn from the diagnostic statistics was that the model was both accurate for the sample and generalizable to the population. On the whole, the assumptions appeared to have been met, and the model appeared not only to be valid for the sample, but was also generalizable beyond the sample.

Thus, the overall conclusion was that after controlling for the effects of the predictor variable *Equity-supportiveness of Organizational Values*, the predictor variable *Equity-supportiveness of Organizational Mission* was a significant predictor of the outcome variable *Whether performance management processes took account of equity or not*.

5.6. 2 Binary Logistic Regression - Outcome 2

In this section, three analyses are reported. The first two are Binary Logistic Regressions involving one predictor and one outcome. These regressions were uncontrolled regressions and were used as a screening tool to select predictor variables for entry into the multiple regression model. The third is a Multiple Binary Logistic Regression with two predictors (which passed the screening) and one outcome variable.

5.6. 2.1 Binary Logistic Regression with One Predictor (Equity-supportiveness of Organizational Mission) and One Outcome

The equity-supportiveness of a healthcare provider organization's Organizational Mission was the predictor variable.

The outcome variable was the presence or absence of an equity-promoting organizational mechanism. The specific equity-promoting organizational mechanism being considered was: whether a Health Equity Audit (or a similar exercise) was performed for the service or not. The two possible responsible categories were: a) Yes, it was, and b) No, it was not.

Interpreting the Logistic Regression Output

A model including the predictor variable *Equity-supportiveness of Organizational Mission* was a better fit to the data than a constant-only model, as measured by the ΔLRS of 14.72, which was statistically significant ($p < 0.001$).

The 'Nagelkerke pseudo-R^2' statistic of 0.336 suggested a well-fitting model.

The null model correctly classified 73.2% of the responses. The 'Classification Table' (below) for the new model correctly predicted 83.9% of the responses. So, the predictive ability of the new model was notably greater than that of the baseline model.

Classification Table[a]

	Observed	Predicted

| | | | Recoded Q. 13a. Is a Health Equity Audit (or a similar exercise) performed for your unit / service?Health Equity Audit is a process in which health care organizations examine inequities in the causes of ill health, and access to health services and their | | Percentage |
			No	Yes	Correct
Step 1	Recoded Q. 13a. Is a Health Equity Audit (or a similar exercise) performed for your unit / service?Health Equity Audit is a process in which health care organizations examine inequities in the causes of ill health, and access to health services and their	No	8	7	53.3
		Yes	2	39	95.1
	Overall Percentage				83.9

a. The cut value is .500

The odds ratio of 1.73 for the predictor variable indicated that as the predictor variable increased by one unit, the predicted odds of the outcome increased by 73% at best estimate. Thus, as the Equity-supportiveness of Organizational Mission increased, the odds of the presence of the specific equity-promoting mechanism in question increased, too.

Thus, the overall conclusion was that the predictor variable *Equity-supportiveness of Organizational Mission* (on its own, without controlling for the effects of the other predictor variable *Equity-supportiveness of Organizational Values*) was a significant predictor of the outcome variable *Whether a Health Equity Audit (or a similar exercise) was performed for the service or not*.

5.6. 2.2 Binary Logistic Regression with One Predictor (Equity-supportiveness of Organizational Values) and One Outcome

The equity-supportiveness of a healthcare provider organization's Organizational Values was the predictor variable.

The outcome variable was the presence or absence of an equity-promoting organizational mechanism. The specific equity-promoting organizational mechanism being considered was: whether a Health Equity Audit (or a similar exercise) was performed for the service or not. The two possible responsible categories were: a) Yes, it was, and b) No, it was not.

Interpreting the Logistic Regression Output

A model including the predictor variable *Equity-supportiveness of Organizational Values* was a better fit to the data than a constant-only model, as measured by the ΔLRS of 11.753, which was statistically significant (p < 0.001).

The 'Nagelkerke pseudo-R^{2}' statistic of 0.284 suggested a well-fitting model.

The null model correctly classified 74.5% of the responses. The 'Classification Table' (below) for the new model correctly predicted 78.2% of the responses. So, the predictive ability of the new model was notably greater than that of the baseline model.

Classification Table[a]

			Predicted		
			Recoded Q. 13a. Is a Health Equity Audit (or a similar exercise) performed for your unit / service?Health Equity Audit is a process in which health care organizations examine inequities in the causes of ill health, and access to health services and their		Percentage
	Observed		No	Yes	Correct
Step 1	Recoded Q. 13a. Is a Health Equity Audit (or a similar exercise) performed for your unit / service?Health Equity Audit is a process in which health care organizations examine inequities in the causes of ill health, and access to health services and their	No	4	10	28.6
		Yes	2	39	95.1
	Overall Percentage				78.2

a. The cut value is .500

The odds ratio of 1.66 for the predictor variable indicated that as the predictor variable increased by one unit, the predicted odds of the outcome increased by 66% at best estimate. Thus, as the Equity-supportiveness of Organizational Values increased, the odds of the presence of the specific equity-promoting mechanism in question increased, too.

Thus, the overall conclusion was that the predictor variable *Equity-supportiveness of Organizational Values* (on its own, without controlling for the effects of the other predictor variable *Equity-supportiveness of Organizational Mission*) was a significant predictor of the outcome variable *Whether a Health Equity Audit (or a similar exercise) was performed for the service or not*.

5.6. 2.3 Multiple Binary Logistic Regression with Two Predictors and One Outcome

As reported above, both the predictor variables turned out to be highly significant predictors of the outcome on their own (when the other variable was not being controlled for). Therefore, using the preceding regression models as a screening process, both these predictors were included in a multiple regression model.

The equity-supportiveness of a healthcare provider organization's Organizational Mission and Organizational Values were the predictor variables. An interaction term between the predictors was not included because it did not seem meaningful in practical terms.

The outcome variable was the presence or absence of an equity-promoting organizational mechanism. The specific equity-promoting organizational mechanism being considered was: whether a Health Equity Audit (or a similar exercise) was performed for the service or not. The two possible responsible categories were: a) Yes, it was, and b) No, it was not.

A backward elimination modelling strategy based on the Likelihood Ratio (LR) method was used for the multiple model because the analysis was a kind of exploratory model-building and the relative importance of the predictor variables was not known in advance. Therefore, a sequential modelling strategy was not suitable. Using this strategy, a final model was derived including only *Equity-supportiveness of Organizational Mission* as a predictor. Hence the model characteristics of the final model were as presented in section 5.6.2.1.

Regression Diagnostics

The residual statistics for the model were good. All the DFBETA values (absolute values) were less than 1. All the Analog of Cook's Influence Statistics were also less than 1.

Normalized Residuals were also calculated to identify data points exerting undue influence. N=54, so, 5% = 2.7 (approx. 3), and 1%. = 0.54 (approx. 1). Five residuals were found to be above ± 2: -2.23 (cases 38, 48 and 93), -3.74 (cases 17 and 97). Two of these residuals were also above ± 2.5.

Another measure of influence that was used was the average Leverage value {(k+1)/n}. Using a conservative cut-off of 3 times the average Leverage value (3*0.04 = 0.12), it was observed that there were no Leverage values appreciably above 0.12.

Thus, three procedures were suggesting that there were no disproportionately influential points, and one procedure was suggesting that there were. Both the Analog of Cook's Influence and DFBETA statistics suggested that there were no outlying values that were unduly influencing the model parameters. These two statistics were more trustworthy, particularly, Cook's as it took into account both the leverage and the magnitude of residuals. Moreover, three of the five Normalized Residuals were only just above expectations, and only two were noticeably above expectations. None of the cases had high Leverage values.

This further allayed any concerns on account of these values. On balance, therefore, it was decided that there were no cases that were exerting undue influence on the model.

The conclusion that was drawn from the diagnostic statistics was that the model was both accurate for the sample and generalizable to the population. On the whole, the assumptions appeared to have been met, and the model appeared not only to be valid for the sample, but was also generalizable beyond the sample.

Thus, the overall conclusion was that after controlling for the effects of the predictor variable *Equity-supportiveness of Organizational Values*, the predictor variable *Equity-supportiveness of Organizational Mission* was a significant predictor of the outcome variable *Whether a Health Equity Audit (or a similar exercise) was performed for the service or not*.

5.6.3 Binary Logistic Regression - Outcome 3

In this section, three analyses are reported. The first two are Binary Logistic Regressions involving one predictor and one outcome. These regressions were uncontrolled regressions and were used as a screening tool to select predictor variables for entry into the multiple regression model. The third is a Multiple Binary Logistic Regression with two predictors (which passed the screening) and one outcome variable.

5.6.3.1 Binary Logistic Regression with One Predictor (Equity-supportiveness of Organizational Mission) and One Outcome

The equity-supportiveness of a healthcare provider organization's Organizational Mission was the predictor variable.

The outcome variable was the presence or absence of an equity-promoting organizational mechanism. The specific equity-promoting organizational mechanism being considered was: whether there was a clear assignment of responsibility in the organization for the promotion of equity or not. The two possible responsible categories were: a) Yes, there was, and b) No, there was not.

Interpreting the Logistic Regression Output

A model including the predictor variable *Equity-supportiveness of Organizational Mission* was a better fit to the data than a constant-only model, as measured by the ΔLRS of 25.58, which was statistically significant (p < 0.001).

The 'Nagelkerke pseudo-$R^{2'}$' statistic of 0.493 suggested a well-fitting model.

The null model correctly classified 88.9% of the responses. The 'Classification Table' (below) for the new model correctly predicted 92.2% of the responses. So, the predictive ability of the new model was notably greater than that of the baseline model.

Classification Table[a]

			Predicted		
			Recoded Q. 3. Is there a clear assignment of responsibility in the organization for the promotion of equity in the provision of care?		Percentage
	Observed		No	Yes	Correct
Step 1		No	4	6	40.0

Recoded Q. 3. Is there a clear assignment of responsibility in the organization for the promotion of equity in the provision of care?	Yes		1	79	98.8
Overall Percentage					92.2

a. The cut value is .500

The odds ratio of 2.28 for the predictor variable indicated that as the predictor variable increased by one unit, the predicted odds of the outcome increased by 128% at best estimate. Thus, as the Equity-supportiveness of Organizational Mission increased, the odds of the presence of the specific equity-promoting mechanism in question increased, too.

Thus, the overall conclusion was that the predictor variable *Equity-supportiveness of Organizational Mission* (on its own, without controlling for the effects of the other predictor variable *Equity-supportiveness of Organizational Values*) was a significant predictor of the outcome variable *Whether there was a clear assignment of responsibility in the organization for the promotion of equity or not*.

5.6.3.2 Binary Logistic Regression with One Predictor (Equity-supportiveness of Organizational Values) and One Outcome

The equity-supportiveness of a healthcare provider organization's Organizational Values was the predictor variable.

The outcome variable was the presence or absence of an equity-promoting organizational mechanism. The specific equity-promoting organizational mechanism being considered was:

whether there was a clear assignment of responsibility in the organization for the promotion of equity or not.

Interpreting the Logistic Regression Output

A model including the predictor variable *Equity-supportiveness of Organizational Values* was a better fit to the data than a constant-only model, as measured by the ΔLRS of 11.499, which was statistically significant (p = 0.001).

The 'Nagelkerke pseudo-R^{2}' statistic of 0.24 suggested a well-fitting model.

The null model correctly classified 88.8% of the responses. The 'Classification Table' (below) for the new model correctly predicted 89.9% of the responses. So, the predictive ability of the new model was greater than that of the baseline model.

Classification Table[a]

			Predicted		
			Recoded Q. 3. Is there a clear assignment of responsibility in the organization for the promotion of equity in the provision of care?		Percentage
	Observed		No	Yes	Correct
Step 1		No	2	8	20.0

Recoded Q. 3. Is there a clear assignment of responsibility in the organization for the promotion of equity in the provision of care?	Yes	1	78	98.7
Overall Percentage				89.9

a. The cut value is .500

The odds ratio of 1.6 for the predictor variable indicated that as the predictor variable increased by one unit, the predicted odds of the outcome increased by 60% at best estimate. Thus, as the Equity-supportiveness of Organizational Values increased, the odds of the presence of the specific equity-promoting mechanism in question increased, too.

Thus, the overall conclusion was that the predictor variable *Equity-supportiveness of Organizational Values* (on its own, without controlling for the effects of the other predictor variable *Equity-supportiveness of Organizational Mission*) was a significant predictor of the outcome variable *Whether there was a clear assignment of responsibility in the organization for the promotion of equity or not*.

5.6.3.3 Multiple Binary Logistic Regression with Two Predictors and One Outcome

As reported above, both the predictor variables turned out to be highly significant predictors of the outcome on their own (when the other variable was not being controlled for). Therefore, using the preceding regression models as a screening process, both these predictors were included in a multiple regression model.

The equity-supportiveness of a healthcare provider organization's Organizational Mission and Organizational Values were the predictor variables. An interaction term between the predictors was not included because it did not seem meaningful in practical terms.

The outcome variable was the presence or absence of an equity-promoting organizational mechanism. The specific equity-promoting organizational mechanism being considered was: whether there was a clear assignment of responsibility in the organization for the promotion of equity or not. The two possible responsible categories were: a) Yes, it was, and b) No, it was not.

A backward elimination modelling strategy based on the Likelihood Ratio (LR) method was used for the multiple model because the analysis was a kind of exploratory model-building and the relative importance of the predictor variables was not known in advance. Therefore, a sequential modelling strategy was not suitable. Using this strategy, a final model was derived including only *Equity-supportiveness of Organizational Mission* as a predictor. Hence, the model characteristics of the final model were as presented in section 5.6.3.1.

Regression Diagnostics

The residual statistics for the model were good. All the DFBETA values (absolute values) were less than 1. All the Analog of Cook's Influence Statistics were also less than 1.

Another measure of influence that was used was the average Leverage value $\{(k+1)/n\}$. Using a conservative cut-off of 3 times the average Leverage value ($3*0.02 = 0.06$), it was observed that some Leverage values were above 0.06: 0.088 (cases 30, 55, 59, 81, 90, and 98), 0.09 (cases 16 and 24), 0.124 (case 4), 0.126 (case 6), 0.127 (cases 12 and 110), 0.128 (case 84).

Normalized Residuals were also calculated to identify data points exerting undue influence.. Four residuals were found to be above ± 2: 2.25 (case 84), -2.3 (case 89), -5.24 (cases 10 and 78). Two of these residuals were also above ± 2.5.

Thus, two procedures were suggesting that there were no disproportionately influential points, and two procedures were suggesting that there were. Both the Analog of Cook's Influence and DFBETA statistics suggested that there were no outlying values that were unduly influencing the model parameters. As these two statistics were more trustworthy, greater consideration was given to their results.

Moreover, most of the aberrant Leverage values and Normalized Residuals were only slightly above expectations. Except for case 84, which had both moderately high Leverage values (0.128) and Normalized Residuals (2.25), none of the cases had both high Leverage values and high Normalized Residuals. This further allayed any concerns on account of these values.

Furthermore, the findings of the model were very clear cut. The model classified a high proportion of cases correctly and the significance level of the key predictors was quite strong. So even if one or two cases were influencing the model (which is unlikely), it was reasonably safe to conclude that they would not greatly alter the inferences. On balance, therefore, it was decided that there were no cases that were exerting undue influence on the model.

The conclusion that was drawn from the diagnostic statistics was that the model was both accurate for the sample and generalizable to the population. On the whole, the assumptions appeared to have been met, and the model appeared not only to be valid for the sample, but was also generalizable beyond the sample.

Thus, the overall conclusion was that after controlling for the effects of the predictor variable *Equity-supportiveness of Organizational Values*, the predictor variable *Equity-supportiveness of Organizational Mission* was a significant predictor of the outcome variable *Whether there*

was a clear assignment of responsibility in the organization for the promotion of equity or not.

5.6.4 Binary Logistic Regression - Outcome 4

In this section, three analyses are reported. The first two are Binary Logistic Regressions involving one predictor and one outcome. These regressions were uncontrolled regressions and were used as a screening tool to select predictor variables for entry into the multiple regression model. The third is a Multiple Binary Logistic Regression with two predictors (which passed the screening) and one outcome variable.

5.7.4.1 Binary Logistic Regression with One Predictor (Equity-supportiveness of Organizational Mission) and One Outcome

The equity-supportiveness of a healthcare provider organization's Organizational Mission was the predictor variable.

The outcome variable was the presence or absence of an equity-promoting organizational mechanism. The specific equity-promoting organizational mechanism being was: whether the promotion of equity in the provision of care was a formal board responsibility or not. The two possible responsible categories were: a) Yes, there was, and b) No, there was not.

Interpreting the Logistic Regression Output

A model including the predictor variable *Equity-supportiveness of Organizational Mission* was a better fit to the data than a constant-only model, as measured by the ΔLRS of 5.52, which was statistically significant ($p = 0.019$).

The 'Nagelkerke pseudo-R^2' statistic of 0.196 suggested a well-fitting model.

The null model correctly classified 92.2% of the responses. The 'Classification Table' (below) for the new model correctly predicted 93.8% of the responses. So, the predictive ability of the new model was greater than that of the baseline model.

Classification Table[a]

	Observed		Predicted		
			Recoded Q. 6. Is the promotion of equity in the provision of care a formal board responsibility?		Percentage Correct
			No	Yes	
Step 1	Recoded Q. 6. Is the promotion of equity in the provision of care a formal board responsibility?	No	1	4	20.0
		Yes	0	59	100.0
	Overall Percentage				93.8

a. The cut value is .500

The odds ratio of 1.59for the predictor variable indicated that as the predictor variable increased by one unit, the predicted odds of the outcome increased by 59% at best estimate. Thus, as the Equity-supportiveness of Organizational Mission increased, the odds of the presence of the specific equity-promoting mechanism in question increased, too.

Thus, the overall conclusion was that the predictor variable *Equity-supportiveness of Organizational Mission* (on its own, without controlling for the effects of the other predictor

variable *Equity-supportiveness of Organizational Values*) was a significant predictor of the outcome variable *Whether the promotion of equity in the provision of care was a formal board responsibility or not*.

5.6.4.2 Binary Logistic Regression with One Predictor (Equity-supportiveness of Organizational Values) and One Outcome

The equity-supportiveness of a healthcare provider organization's Organizational Values was the predictor variable.

The outcome variable was the presence or absence of an equity-promoting organizational mechanism. The specific equity-promoting organizational mechanism being considered was: whether the promotion of equity in the provision of care was a formal board responsibility or not.

Interpreting the Logistic Regression Output

A model including the predictor variable *Equity-supportiveness of Organizational Values* was a better fit to the data than a constant-only model, as measured by the ΔLRS of 0.233, which was statistically non-significant (p = 0.629).

The 'Nagelkerke pseudo-R^{2}' statistic of 0.009 suggested a poorly fitting model.

The null model correctly classified 92.1% of the responses. The 'Classification Table' (below) for the new model correctly predicted 92.1% of the responses. So, the predictive ability of the new model was the same as that of the baseline model; there was no improvement in predictive ability by adding this predictor.

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Classification Table[a]

	Observed		Predicted		Percentage Correct
			Recoded Q. 6. Is the promotion of equity in the provision of care a formal board responsibility?		
			No	Yes	
Step 1	Recoded Q. 6. Is the promotion of equity in the provision of care a formal board responsibility?	No	0	5	.0
		Yes	0	58	100.0
	Overall Percentage				92.1

a. The cut value is .500

The predictor variable *Equity-supportiveness of Organizational Values* was a non-significant predictor of the outcome variable ($p = 0.623$).

Thus, the overall conclusion was that the predictor variable *Equity-supportiveness of Organizational Values* (on its own, without controlling for the effects of the other predictor variable *Equity-supportiveness of Organizational Mission*) was *not* a significant predictor of the outcome variable *Whether the promotion of equity in the provision of care was a formal board responsibility or not*.

5.6.4.3 Final Model

As reported above, only one of the two possible predictor variables (*Equity-supportiveness of Organizational Mission*) turned out to be a highly significant predictor of the outcome on its

own (when the other variable was not being controlled for). Using the preceding regression models as a screening process, the second non-significant predictor *Equity-supportiveness of Organizational Values*) was excluded from the final model. Therefore, the final model consisted of only the first predictor variable *Equity-supportiveness of Organizational Mission* and the outcome variable *Whether the promotion of equity in the provision of care was a formal board responsibility or not*. The final model was identical to the first model presented in section 5.6.4.1. Since its model parameters have already been reported earlier, they are not reported again. Next, the generalizability of the model to the wider population is considered through an examination of the residual statistics.

Regression Diagnostics

The residual statistics for the model were good. All the DFBETA values (absolute values) were less than 1. All the Analog of Cook's Influence Statistics were also less than 1.

Another measure of influence that was used was the average Leverage value {(k+1)/n}. Using a conservative cut-off of 3 times the average Leverage value (3*0.03 = 0.09), it was observed that some Leverage values were above 0.09: 0.184 (cases 4 and 12), 0.192 (case 110), 0.272 (cases 6 and 84), 0.4 (cases 23 and 27), 0.44 (case 42).

Normalized Residuals were also calculated to identify data points exerting undue influence. Three residuals were found to be above ± 2: -4.1 (cases 5 and 48), -6.5 (case 76). All three residuals were also above ± 2.5.

As reasoned in the case of the previous outcome, it was decided that there were no cases that were exerting undue influence on the model.

The conclusion that was drawn from the diagnostic statistics was that the model was both accurate for the sample and generalizable to the population. On the whole, the assumptions appeared to have been met, and the model appeared not only to be valid for the sample, but was also generalizable beyond the sample.

Thus, the overall conclusion was that after controlling for the effects of the predictor variable *Equity-supportiveness of Organizational Values*, the predictor variable *Equity-supportiveness of Organizational Mission* was a significant predictor of the outcome variable *Whether the promotion of equity in the provision of care was a formal board responsibility or not.*

Chapter 6: Discussion of Findings

This chapter begins by summarising the findings from the statistical analyses described earlier and suggests some practical implications of these findings for NHS and Social Enterprise healthcare provider organizations. After this summary, the next section discusses these findings in greater detail, unpacking their ramifications for the future provision of public services. The last section describes the major organizational changes that have taken place in the Social Enterprises studied in this research project and the impact these changes have had on the equity-supportiveness of their organizational cultures.

6.1. Summary of Findings from the Statistical Analyses and Practical Implications

In this section, the main findings from the statistical analyses carried out earlier are stated. The implications of these findings for NHS and Social Enterprise healthcare provider organizations are then suggested.

6.1.1 Findings in Relation to Organizational Mission and Organizational Values

Statistical testing through the Independent Samples t-tests revealed no evidence for any significant differences between NHS organisations and Social Enterprises in respect of the equity-supportiveness of their organisational missions, values, and the importance given by their staff to equity issues. Neither were there any statistically significant differences between the two classes of organizations in terms of the presence of equity-promoting organisational mechanisms.

The uniformity of the non-significant findings in the t-tests and chi-squared procedures may be explained by the similarity of the outcomes being tested in these procedures. It was to be expected that if the two types of organisations did not differ in respect of the equity-

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supportiveness of their organisational missions and values, they would not differ in terms of the presence of equity-promoting organisational mechanisms either. In a way, the absence of significant differences in the chi-squared tests may be seen as confirming a similar outcome in the t-tests, thereby, increasing the reliability of the findings.

That the Social Enterprises examined in this project did not differ notably from the NHS organizations in these respects may perhaps be because Social Enterprises have not been established long enough for large differences in culture to open up, and also perhaps because many Social Enterprise staff worked formerly (and, in many cases, for long periods of time) in NHS organizations.

The regression analyses revealed the key variables that influenced the degree of importance given by healthcare staff to equity issues (a likely important predictor of equitable behaviour by healthcare staff). Using regression, the Equity-supportiveness of Organizational Mission and the Equity-supportiveness of Organizational Values were identified from all the possible variables as the best predictors of 'Importance given to Equity by Staff'. The regressions suggested that the Equity-supportiveness of Organizational Mission was the most significant predictor, followed by the Equity-supportiveness of Organizational Values. This suggested that the organization's core purpose or mission is extremely important for the promotion of equity. The practical implication for healthcare organizations is that maintaining a strong focus on their aim of serving the public is vital to promote equity in provision of care. This means collecting data on equity, monitoring it to assess disparities in care, and taking action to close those gaps. The challenge for public healthcare organizations will be to maintain a strong focus on their fundamental reason for existing (to serve the public, to promote equity, fairness and social justice, to provide universal healthcare) in an environment of acute financial pressure and stretched resources. If the organization's core purpose is diluted, for example, due to financial considerations taking precedence (as in the case of Mid-Staffordshire NHS Trust), it may eventually undermine equity in service provision. For Social Enterprises, keeping the 'Social' of Social Enterprise at the heart of their activities will be crucial as there are many instances in the literature of *mission creep* where the social purpose of organizations gets eroded over time due to increasing commercialization and marketization.

Organizational values are also essential to the promotion of equity. This means firstly, enshrining fairness and equity at the heart of organizational values, and, secondly, communicating values clearly, promoting the values throughout the organization, socializing staff into the values through training, performance management, and coaching, and operationalization of the values by embedding them into all important systems and processes.

It is argued here that the organizational values of *public* healthcare providers such as the NHS tend to involve higher ethical standards than those of *private* healthcare providers. Public providers such as the NHS are required to abide by a set of ethical standards known as 'The Seven Principles of Public Life', also referred to as the 'Nolan Principles' (after Lord Nolan who chaired the Committee for Standards in Public Life which prepared the report) (Committee on Standards in Public Life, 1995). These principles define the ethical values that public organizations and public office holders are expected to adhere to. They are:

1. Selflessness: Holders of public office should act solely in terms of the public interest.

2. Integrity: Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.

3. Objectivity: Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.

4. Accountability: Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.

5. Openness: Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.

6. Honesty: Holders of public office should be truthful.

7. Leadership: Holders of public office should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs.

(Committee on Standards in Public Life, 1995)

These principles have been interpreted in the following manner by the Heart of England NHS Foundation Trust:

'PRINCIPLES OF CONDUCT IN THE TRUST

Trust employees are expected to:

Ensure that the interests of patients remain paramount at all times;

Be impartial and honest in the conduct of their official business;

Use the public funds entrusted to them to the best advantage of the service, always ensuring value for money;

Understand and uphold the Nolan principles to all areas of their work for and on behalf of the Trust.

It is the responsibility of employees to ensure that they do not:

Abuse their official position for personal gain or to benefit their family or friends;

Accept bribes;

Seek to advantage or further their private business or other interests, in the course of their official duties;

Breach any statutory legislation or Trust policies whilst conducting business on behalf of the organisation.'

(The Heart of England NHS Foundation Trust, 2013; p. 1-25)

The Nolan Principles and their interpretation by one NHS Trust (the Heart of England NHS Foundation Trust) are quoted here to make the argument for a potential disparity between the ethical standards that public and private organizations are required to adhere to. Some of the Nolan Principles which are expected of public office-holders, such as selflessness, not advancing personal interest in their public role, openness and accountability are so markedly different from the values that are commonly understood to motivate people working in private, for-profit organizations that it is hard to envision how a private, for-profit healthcare provider contracted to deliver a public service could simultaneously uphold both sets of public and private values.

While there is nothing barring private healthcare providers from adopting the high ethical standards that the Nolan Principles exemplify, and many private providers, perhaps, do, there is not the same statutory requirement for them to do so as there is for public healthcare providers. In the absence of this requirement, it seems reasonable to speculate that the standards of ethical behaviour will be lower in private providers of healthcare. It is true that some public providers also fall short of these standards. However, the expectation for public providers to subscribe to these principles, enshrined in law, creates pressure on all public providers to comply which will ensure that most of them will abide by these principles. The same pressure does not apply equally, or applies with less force and rigour, to private providers of public services. Thus, the latter's ethical standards are likely to be lower, not due to any inherent flaw in the organizations themselves but just because the pressure to do so isn't there. Thus, the creation of a uniform playing field to ensure fair competition might require private, for-profit providers of public healthcare services to accept a similar requirement for ethical standards in their public service delivery role.

6.1.2 Findings in Relation to Equity-promoting Organizational Mechanisms

Regression analyses were used to identify which of the four equity-promoting organizational mechanisms were the best predictors of 'Importance given to Equity by Staff'. The regression analyses suggested that after controlling for other variables 'Clear Assignment of Responsibility for Equity' was the most significant predictor, followed by 'Equity Performance Management Processes'.

This suggests that the clear assignment of responsibility for equity is extremely important for the promotion of equity. This may take the form of a dedicated Equalities Lead or team as is common in many NHS Trusts, or it may take the form of a specific individual who shares the responsibility of leading on equity along with other duties. What is of import is that all staff know who this individual is, and how to contact them should any equity issues arise in their service. It is also important that this individual or team have a real commitment and appropriate powers to drive the equity agenda effectively.

The second implication for healthcare organizations is that considerations of equity need to be embedded in routine performance management processes in order to make the promotion of equity a way of life. When performance evaluations and the allocation of promotions, rewards, status, incentives, etc. become contingent on the advancement of equity, staff are likely to take notice.

6.2 Discussion of Findings

The statistical analyses presented in the *Analysis and Results* section suggest that the answer to the first question – do the organizational cultures of NHS organizations and Social Enterprises differ in their equity-supportiveness – is no. At present, the differences are not

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statistically significant. The null hypothesis for the research project (H_0: The organizational cultures of hybrid and public organizations are equally supportive of equity) could not be rejected. This is not surprising given that many of the Social Enterprises spun out from the NHS fairly recently (within the last ten years), are almost entirely reliant on the NHS for their main contracts, and are heavily regulated by the NHS, and are still heavily comprised of ex-NHS staff (many of whom have spent decades in the NHS and are steeped in NHS values and ways of working).

The findings were slightly counter-intuitive since the accepted wisdom in debates about the organization of healthcare is that the delivery of public health services should be done by publicly-owned and publicly-run healthcare organizations. The findings suggested that Social Enterprise organizational cultures showed slightly greater equity-supportiveness (though the differences were not statistically significant). Some possible reasons for this finding are suggested in the next section. It is argued in the next section that Social Enterprises have made some organizational changes that increase the potential for higher quality of care, innovation and equity. The next section (which presents the analysis of the interview data) describes some of these organizational changes and the likely impacts on equity in service provision.

A finding from the *Results* section was the importance of an organization's mission, values and equity-supportive mechanisms for the promotion of equity. All three were predictors of the degree of importance that staff gave to equity (importance given to equity being a likely determinant of equitable behaviour). As stated earlier, one of the questions that inspired this research project was: Which organizational factors really matter for the promotion of equity? This question can now be answered: organizational mission, values and equity-supportive mechanisms. Organizational mission and values are, however, more important as they are the fountainheads from which organizational mechanisms flow. Organizational mechanisms give expression to the organization's mission and values. Therefore, for the establishment of equity-supportive mechanisms, the prior conditions are that the organization's mission and values must have equity at their heart.

Given the vital importance of organizational mission and values for the promotion of equity, it is worth commenting on the differences between the organizational missions and values of public organizations (like the NHS) and Social Enterprises and the implications for equity. There is an expectation from public healthcare providers (like NHS organizations) that they will promote equity, fairness, and social justice, that they will assist in neutralising and reducing some of the societal inequalities that result in people from various socio-economic strata having unequal opportunities to pursue good health. This expectation is institutionalised in the NHS Constitution which guides the behaviours of NHS organizations (Department of Health, 2015). Organizations providing public health services are expected to have as their core mission or purpose the aim of serving the public good. It is expected from public health services that they will be under-girded by certain core values, some of which are universal access to care, fairness and equality, compassion, professionalism and excellence, transparency and accountability. This public service mission and these core values are accepted and subscribed to by probably all NHS organizations. This assertion can be made in the case of Social Enterprises with equal confidence for the present. However, there are some grounds for concern about their behaviour in the future. This is explained more fully below.

It has been argued above that equity-supportive organizational mission and values are essential to the promotion of equity in public service provision. A question then arises: 'whose mission and whose values'? As long as the same organization funds and provides the services, the answered to this question is not problematic. However, the separation of the purchaser and provider functions in NHS-funded services, and, in particular, the provision of funding by the NHS but the actual delivery of care by Social Enterprises problematizes the issue of 'whose mission and whose values'.

It is clear that the organization financing the services and the organization actually delivering the care have to agree on the core purpose and core values that must underpin the delivery of care. At present, this is not likely to be an issue as Social Enterprises are almost entirely reliant on their NHS contracts for survival. The NHS, thus, wields a great deal of influence over how the care is delivered. Therefore, the NHS mission and values become the *de facto* basis for the care provided by Social Enterprises. The NHS sets the standards of care, and Social Enterprises must comply with those standards. Moreover, the constitutions and the Articles of Association

of Social Enterprises require them to give primacy to their social mission. As Community Interest Companies, their legal structure is geared to the performance of a public service or at least a socially responsible function.

However, the structural independence of Social Enterprises and the potential Trojan horse of being simultaneously a profit-maximising business means that they are, in principle, capable of deciding on a different future for themselves. An asset lock and restrictions on distributing dividends are not sufficiently strong inhibitions to prevent Social Enterprises from pursuing a different vision of their future. Over time, as Social Enterprises diversify their businesses, generate new sources of revenue, and become more independent of the NHS, they are less likely to accept the diktats of the NHS. As Social Enterprises acquire more control over their financial destinies and become less dependent on the NHS, they are likely to become more capable of charting a different direction of travel for the future and veering away from the mission and the values of the NHS. If they choose to adopt a different purpose and different values, there is a risk to the sustainability and continuity of NHS, i.e., public service provision.

Further, the NHS, as a publicly-owned and publicly-run organization, is exposed to a degree of public scrutiny and control that the relatively more private Social Enterprises are not. As privately-owned organizations (even if employee-owned, they are still privately-owned), Social Enterprises are less accountable to the public. The lower degree of public scrutiny and control that Social Enterprises face heightens the risk of a divergence from the aims and values of a public service and a possible erosion of their public service ethos over time.

The spinning out of Social Enterprises from the NHS has resulted in shrinkage of the formal public sector and the reduction of public sector capacity, with attendant adverse consequences for equity. While the size of the healthcare Social Enterprise sector relative to the NHS is small at present (being confined to erstwhile community healthcare NHS Trusts), a strategy of large scale externalisation of NHS services through mass adoption by *acute* NHS Trusts of the social enterprise model (as is being planned by the Cabinet Office of Mutuals), without adequate replacement of publicly owned facilities, is likely to increase the risks of adverse effects on equity that are associated with full-scale privatisation. Given that most of the staff currently

working in Social Enterprises are ex-NHS staff who are strongly rooted in the NHS's public service aims and values, these possible adverse effects on equity are not likely to materialise in the short run but perhaps may become more serious in the long run, especially if the trend towards externalisation of NHS services continues or accelerates.

This research project began by asking the question: does the externalisation of parts of the NHS as Social Enterprises pose risks to equity, or can public health services be provided as equitably and fairly by Social Enterprises as by publicly-owned and publicly-run organizations such as the NHS? The answer suggested by this research project is that at present and in the near future, there may not be a risk to equity from the externalisation of parts of the NHS as Social Enterprises but in the long run there may be.

While the argument has hitherto been critical of Social Enterprises, it ought to be emphasized that the risks suggested above are speculative and based in the future. It is clear, however, that in the present Social Enterprises are doing wonderful things, organizationally, that harbour potential for significant improvements in equity. There are some valuable lessons for the NHS from the changes that Social Enterprises have made. The Social Enterprises studied in this project have been successful experiments in organizational innovation. They are, in many respects, the vanguard of organizational change, reform and modernisation of public services. The next section describes some of the organizational changes made by Social Enterprises and the likely impacts on equity in service provision.

Given the inexorable reality of a mixed economy of public service provision, it is the aim of this section to give examples of various organizational mechanisms that have the potential to improve equity in care provision in all kinds of provider organizations – public, private and social enterprise. Particular attention will be paid to the organizational mechanisms identified in the statistical analyses as being important for equity. This section attempts to answer the second question that motivated this research project: how can organizations of all shades (public, private, social enterprise) make healthcare more equitable? Which organizational practices improve equity and how? The purpose of this section will be to a) describe the organizational changes in social enterprises relative to NHS organizations and b) to draw out

the implications of some of these organizational changes for equity in service provision. Many benefits have been claimed for Social Enterprises but, as the National Audit Office report on Social Enterprises (2011; p. 6) states, there is relatively little 'hard evidence' of the benefits that Social Enterprises are delivering. This section purposes to supply some of the evidence.

A Note on the Rationale for the Selection of Themes in the Qualitative Data Analysis

The themes that were given priority during the qualitative data analysis were the ones identified during the literature review as the crucial influences on organizational equity culture. These themes (organizational mission, values, performance management mechanisms, leadership, innovation, etc.) had been selected through the literature review as the key explanatory variables for explaining differences in the equity-supportiveness of the cultures of NHS organizations and Social Enterprises. These variables referred to characteristics of organizations or practices within organizations that exerted a significant influence on the organization's culture.

These themes (or explanatory variables) were based on Schein's (1985) influential model of organizational culture. The literature on Social Enterprises and health equity was also consulted in the process of identifying these themes. These particular organizational categories were chosen because they were considered to be useful for understanding healthcare organizations' performance in promoting equity. Furthermore, as these organizational practices accounted for some of the main differences between NHS organizations and Social Enterprises, they seemed relevant to this research project which attempts to describe and explain differences in the organizational performance of NHS and Social Enterprise providers. Thus, these themes (or explanatory variables) were the principal components of the theoretical framework which was used to explain the differences between the two types of organizations. Derived from the theoretical literature on organizational culture, these themes served as springboards for detailed analysis of the qualitative data. The eight themes that were identified in advance were:

1. Organizational Mission and Identity

2. Organizational Values

3. The Clear Assignment of Responsibility in the Organization for the Promotion of Equity

4. Performance Management (Targets) and Incentive Systems

5. Role of Leadership

6. Bureaucracy and Ease of Decision-making

7. Autonomy and Empowerment

8. Extent of Employee Involvement in Strategic Decision-making

The main themes were identified in advance, and the analysis of the qualitative data was intended to test the value of these themes for explaining the differences between the two key groups of organizations. It is acknowledged that a more structured, directed approach was taken to the analysis of the qualitative data than is customary in qualitative data analysis where the convention is to analyse data in a more open-ended, inductive way and allow themes to emerge from the data (most notably in Grounded Theory). This approach to data analysis, though somewhat at variance with the traditional approach to qualitative data analysis, was in keeping with the dominant positivistic, quantitative thrust of this research project. Positivistic, quantitative approaches tend to employ a hypothetico-deductive method of inquiry where a theory is postulated in advance, and elements of the theory are then tested through the collection of empirical data. Though this method was not followed as rigidly as it is done in positivistic, naturalistic studies in the physical sciences, something of its spirit was present in the analysis.

These themes met the conventional tests of repetition and high frequency, of explaining key similarities and differences in the outcomes, of being of significance to the interviewees, and assisting in answering the research questions. Taken together and viewed as a whole, the themes offered a synthetic, integrated perspective on the systems and processes underlying

the organizational cultures of healthcare providers. The themes linked this research project to the well developed tradition of organizational culture research and made clear its lineage. The value of these themes was also buttressed by their significant overlap with other prominent literature dealing with the organization of public healthcare such as the Francis Report into the Mid-Staffordshire NHS Foundation Trust (Francis, 2013).

It should be noted that the themes that were privileged for development during data analysis were pre-conceived in a very broad, capacious way, and not in a restricted, tightly defined way. These pre-selected themes provided a skeleton framework to which flesh was added during the data analysis. When the data was being analysed, concrete instances were selected to support or challenge these central themes, to identify sub-themes and to explicate the differential manifestation of these themes in different types of organizations.

While the majority of the themes were selected *a priori*, an open mind was kept to the possibility of additional themes being generated by the process of qualitative data analysis. In fact, three themes – Innovation, Use of Technology, and Service User Involvement and Co-production – had not been identified in advance and emerged inductively as key differences between NHS organizations and Social Enterprises. Thus, the selection and the elucidation of themes was done in a structured, directed manner but was by no means a rigid, inflexible or close-minded process. That there were eleven themes in the final analysis indicates that the original theoretical framework held up well in the light of the empirical evidence, and the new themes improved the explanatory power of the framework. The procedural details of qualitative data analysis and the process through which the themes emerged are explained in more detail below.

The Process of Emergence of Themes in the Qualitative Data Analysis

All the interviews were audiotaped. The audiotapes of the interviews were transcribed and the transcripts were analysed thematically. Themes were compared across individuals to identify cultural themes, which were themes held simultaneously by many different people in the

organization (Sackmann, 1991). The thematic analysis of the responses enabled the researcher to obtain detailed, in-depth information about cultural change in hybrid organizations.

King and Horrocks (2010) define themes as 'recurrent and distinctive features of participants' accounts, characterising particular perceptions and / or experiences, which the researcher sees as relevant to the research question' (p. 150). According to Braun and Clarke (2006), a theme encapsulates an important finding in relation to the research question, and indicates a pattern of meaning or significance within the data collected. To conduct thematic analysis, the audio-recordings of the interviews were transcribed. The text was then read several times to gain familiarity with the ideas. In the first stage of analysis, an initial list of descriptive codes was created to highlight those parts of the transcript that were useful in answering the research question (King and Horrocks, 2010). According to Braun and Clarke, codes mark those parts of the text that appear relevant and significant to the analyst in the light of the research questions. This process of coding was done iteratively several times to exhaust the possibility of finding new codes. As Braun and Clarke (p. 18) explain, coding is 'organising your data into meaningful groups'.

In the next stage, themes were identified and the codes were organized within these themes. In this process, the relationships between codes were examined; patterns were identified; hierarchies of codes were created; and codes were sorted into different categories. Theories relevant to the research questions were used to assist in the identification of themes. This process produced an initial list of themes. This process of theme identification was undertaken recursively several times to ensure that as many potential themes and sub-themes as possible had been identified. Sub-themes are 'essentially themes-within-a-theme'; they help to structure large and complex themes (Braun and Clarke, p. 22). The themes were then reviewed and refined by repeating the whole process over again several times. A thematic map was prepared linking the different themes (and different levels of themes) to encompass the entire data set. The themes were then defined, clarified and their boundaries delimited. They were tested for coherence and explanatory power. The final themes were then collated to create a narrative and an argument for the report (Braun and Clarke, 2006).

6.2.1. Organizational Mission and Identity

In this section, the changes in the organizational mission and identity of Social Enterprises and the impacts on the equity-supportiveness of their organizational cultures are explored.

As has been stated earlier, Social Enterprises straddle the middle ground between the public and the private sector. Classed as *hybrid organizations*, they attempt to both serve the public interest like a public organization and maximise profits like the private sector (Smith et al. 2013; Doherty et al., 2014; Teasdale, 2012). More self-consciously businesses than NHS organizations, social enterprises aim to generate maximum profits but re-invest the majority of the profits they generate into the service or the community to provide better care. While Social Enterprises don't pay dividends to shareholders as the private sector does, when they make profits they do give their staff pay rises and bonuses when they meet their targets as an incentive for performance. Thus, the profit motive and the financial imperative of being a business exists in Social Enterprises but is tempered by its social mission. It is not surprising, therefore, that many social enterprise staff view themselves as working for a not-for-profit organization. However, there can be tensions in serving two masters and this section aims to bring out some of those tensions.

The transition to social enterprise has engendered a more acute cost-consciousness and sensitivity to finances in its employees. By and large, this has been a blessing but in some cases it has had an adverse impact on equity. The extract below demonstrates how the cost savings and reductions in resources available to staff have had a potentially negative impact on equity. This organization works in an extremely deprived area and a lot of patients rely on the transport provided by the organization to access the service. Along with other cuts, funding for transport for patients has been cut, thus, reducing equity of access for the poor.

Interviewer: Has there been any impact of working in a Social Enterprise on the way you do your work?

Interviewee: With regards to money, I think, definitely. With regards to funding for simple things such as uniforms, we have had big, big cutbacks. A lot of us buy our own uniforms now because they say we can't have them. And just simple things like stationery that we need for our job - we have had big cuts. For silly things really. For necessity things we need. Also, cutbacks that have affected us here on a personal level as a service has been our transport. Patients, probably, 8 out of 10 of our patients can't use this service unless we provide them with transport. So, that has been a big issue with us.

However, staff in other Social Enterprises suggested that the potential tensions between profit-maximizing and providing a fair service had not materialised: 'I haven't seen it myself. Not at all. I am not aware of it. I mean, obviously, one of our objectives is about income generation and cost improvements and making savings wherever we can but not to the detriment of patients.' Other interviewees suggested that even the NHS is being run more and more like a business, so there is little real difference between the NHS and Social Enterprises when it comes to providing a fair, equitable service. In the extracts below, two interviewees argue that the NHS, while offering a fair, equitable service is doing so at a cost that is no longer sustainable and that social enterprises might be able to bridge the two aims of promoting social justice and being financially viable.

Extract 1:

Interviewer: The literature on Social Enterprises suggests that there can be tensions between being a business and pursuing the aim of profit-maximisation and providing equitable care. Have you experienced these tensions or is it a theoretical risk that has not materialised in practice?

Interviewee: For me, I wouldn't be working here if that was the case [said this with confidence which suggests conviction and honesty]...So, yes, it is a business but, actually, the NHS is a business as well. If you think of acute trusts, they work for

tariffs, don't they? Without letting patients come in, they haven't got a service, have they, and they haven't got money. And, actually, in many ways, you could say that the acute trusts are paid and there is an inappropriateness in relation to the NHS...I actually don't see any difference. The NHS is the same. The problem is that we have just not been aware of it. We have this lovely view of the NHS but, actually, it has been run like that for years. That is why we are in a lot of debt but for a social enterprise the same thing applies except they have got a bit more individuality, and they can influence things a bit more. So, if anything, the small amount of resources that we are given, we can use those resources more efficiently, and that's what seems to be the bonus for me for working in a social enterprise. Foundation Trusts are businesses on their own but they are so inefficient. It is a business that is poorly run, except I am working for a business that is still about patients but, actually, it is better run...That is why I left a big mental health foundation trust. That was also after money, business, but just wasn't managing it very well.

Extract 2.

Interviewee: Mid-staffs and the focus on finance. You could say that there is more and more of it, including at [the local comparable NHS Trust]. [There is] more of a focus on finance [in more and more NHS Trusts]. It is all very well saying that they have got a public sector ethos but if the budget is blown every single year, and they are getting into bigger and bigger debt, then, [there is] not much point in playing, is there really? Because, clearly, they are delivering it but they are delivering it at a price and at a cost that is just not affordable. Something has got to change somewhere. And it is getting harder, because the commissioners will give us less as well in the future but we have got to cut our cloth accordingly...There will be less money around.

Another employee suggested that the tensions were real, however, they hadn't affected the quality or fairness of care yet. In the extract below, she describes the potential downsides of

being a profit-maximising, private entity. She suggests that the business imperative of income generation was putting pressure on clinical services by drawing away the time and energy of staff and that there was a risk that quality and equity could be compromised. However, this hadn't happened yet, she asserted.

Interviewee: It is a very good question. Yes and no, is what I would say to that question. Yes, because we are a business, so, we have to bring money in. The way the majority of our money comes in is through commissioning. So, they commission our services and they give us X amount of money. Although the government is investing in the NHS,...there are still real cuts that have to be made, and us as an organization, [we get] less from the commissioners to do the same. You are expected to do more for less really, every year, every single year. And, so, there is a real pressure to deliver financially as an organization, and a pressure that probably was different when we were fully part of the NHS because if NHS organizations fail, generally someone bails them out. They won't bail us. We have to be our own financial institutions. We have to make money, break even. So, there is a pressure on [us], and I would say that I have felt that tension. It has been in the NHS for a while because savings have had to be made for years. When I can remember, when I worked in the hospital, we had to cull posts because of, we had to make X amount of savings. So, this is not a new thing. What potentially that does do within our model, us being perhaps a little fragile because we haven't got a saviour, is that you do have to go out and try and tout the business. We have got to try and get more business. There is always a risk when you do that that you spread yourself too thinly. And, as a small organization, where you haven't maybe got corporate structures there with lots and lots of business development teams, that can purloin other folk to go and do that. So, there is always a risk that you then lose clinical quality or, you know, impact on safety, or all of those kinds of things. So, absolutely, and I think there is a real fine balance. This kind of tension has to be, sort of, managed. You need to get investment, and all the time there is pressure on me as a clinical services manager to look at how can you do things differently, can you be more productive, can you income-generate in some way, can you put in a business case for this, that and the other? There is always that kind of tension. So, yeah, I don't know if it has affected clinical quality yet.

The social enterprise model has been an attractive option for governments because, historically, social enterprises have often emerged to meet gaps in public service provision (Sepulveda, 2015; Teasdale, 2010). They have often been at the vanguard, working in under-served areas to address inequities in mainstream service provision and serve patients who are excluded from mainstream services. They have often catered to the needs of the vulnerable and the marginalised who haven't been served well by regular public services. So the *social* aim of Social Enterprise has historically dominated and it is why they have been at the forefront of promoting equity. There is a clear potential and an opportunity for the *enterprise* or business side to complement and strengthen the *social* side. As one interviewee said, 'If you think about a Social Enterprise as kind of a business model, there is potential that a good business leader would think that the way to get money in is to try and access hard-to-reach people, to create funds or services or deliver things differently or meet a need.'

Another way in which Social Enterprises has traditionally distinguished themselves from the public and private sectors is in adding extra social value by creating additional positive outcomes for their staff, their service users, the community, the local economy and the environment (Department of Health and Social Enterprise Unit, 2010, 2011; Westall, 2009; Nicholls, 2007). For example, in addition to providing the necessary contracted-for care, Social Enterprises assist their clients in becoming more independent, resilient and capable. In the extract below, one senior manager explained how their Social Enterprise was adding social value to their employees and clients. He described how the *social* aim of their Social Enterprise was being given meaning in their organization and the mechanisms they had instituted to preserve their social mission. He described how they were treating their Home Care Workers more fairly and humanely by offering them a living wage whereas the market offered them only a minimum wage and sometimes not even that. They were also treating their Home Care clients with more humanity and dignity by offering them 30 minute appointments instead of the market norm of 15 minute appointments.

> Interviewee: Being a social enterprise of the sort we are, being a Community
> Interest Company means that we can't pay dividends, we have an asset lock, we

have articles of association which mean that we have a Members' Council...the Members' Council have a say on behalf of the members in how the business is run. We have a Board of Directors, and that input from the Members' Council is very different from a private sector organization...We have got a...not just a social conscience but we have got a social requirement put on us by our Articles of Association that mean that we can't operate like a business.

Interviewer: Could you please tell me a bit more about this social conscience because that is really important?

Interviewee: It is a fine line between that and corporate social responsibility, isn't it really? Which is the point you made at the start, wasn't it really? Is there a difference between those two things? I think we are probably aspiring to some of this rather than necessarily doing it but we aspire to be having a focus of more of our colleagues on the difference that we make to social value. We started with probably the things you could say are more corporate social responsibility type things. So, we work with a school in [name of place], we have a community fund that is managed by our Members' Council that has supported forty three local charitable organizations with small grants to do things that have changed, you know, seriously changed their capacity and ability to do stuff. Those things, in a way, you could say, well, that is part of any organization's corporate social responsibility.

Interviewer: Most NHS organizations have their own charitable wings which do...

Interviewee: ...some of those things. The bit of it that turns it round is that we are starting to get, we have run a pilot this year in our children's business unit of giving matching time with our staff colleagues, offering them time for volunteering. The real holy grail on it, I guess, is in terms of being able to really understand it better is in what we do, as a health organization, what is the difference that we make to the person, not in their health, but in their wellbeing. So, what is the social value that we add through the care that we give, exploring that. We have begun to explore that. The easiest example is rehabilitation, in that you can measure somebody's ability to be independent at the start of the rehabilitation process and at the end of it. You could take that into a number of other areas of care and start to explore some more of that.

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Another one for you, another good example is that we have set up a subsidiary, which is [name of social enterprise] Home Care. So, we have got the opportunity with our [name of social enterprise] Home Care business to provide a continuum of social care support through to medical care in the community. That Home Care business, you will have probably seen in the press about home care. Often, a lot of these companies offer very short home visits - 15 minutes - to a person to get them dressed, for instance. Em, they often pay very poorly, and quite often, below the minimum wage, but we have set this organization up, and it is still growing. We offer a minimum of half hour appointments. We don't do less than a half hour appointment so that the person we are visiting in the home feels like we are there to support them.

Thus, it is evident that the changes made by Social Enterprises to their organizational mission and identify have, in most cases, strengthened their social mission and have contributed to the more effective promotion of equity. In some instances, concerns persist, and it remains to be seen how they are addressed.

6.2.2. Organizational Values

In this section, the changes in the organizational values of Social Enterprises and the impacts on the equity-supportiveness of their organizational cultures are discussed.

Organizational values are clearly key to the promotion of equity. If an organization's values are supportive of equity, it will make equity essential to all recruitment, promotion and retention decisions; it will educate all staff on equity-related issues and train them to be sensitive to differences of culture, gender, class, religion, etc.

An important theme to emerge from the analysis was that social enterprises were doing a much better job of articulating, promoting and practising their organizational values. It will be

recollected that organizational values are about the kinds of behaviour that an organization values in its employees (Somers, 2001; Meglino and Ravlin, 1998). For example, acting with compassion and behaving ethically are common values for many healthcare organizations. Values are the kinds of behaviour that are actually valued and practiced. In an organization that truly values honesty and openness, admission of mistakes or below-standard care is encouraged; if admission of mistakes and concerns about quality of care is discouraged, then, honesty and openness are not the organization's true values.

Though NHS organizations have strong values, it is often assumed that all staff share those values and live them from day to day. However, as the scandal of shockingly poor care and neglect of patients at the Mid-Staffordshire NHS Trust showed, there is often a wide gulf between values as espoused on the organization's promotional materials and the values that are actually practised on a daily basis. Social enterprises, in the process of defining, crafting and refining their identity have given a lot of thought to what their values should be and how best to ensure congruence between the organization's values and operational practice. They have, therefore, gone to great lengths to emphasize and communicate their values. In visiting a social enterprise, the researcher found that it was hard not be reminded of the values – they were everywhere, on walls, on doors, etc. This organization put their organizational values on information that it sent out to staff and patients. An Operations Manager described the reasoning behind this: 'I think, sometimes you just need to remind people of how we expect people to be treated and how they would want to be treated as well.' Some social enterprises, as the extract below indicates, set up separate days and dedicated events for the inculcation and socialization of staff into the new Social Enterprise values.

> Interviewee. I don't know whether anybody has talked about our cinema values work that we did. So, the cinema in [geographic location] at The Odeon. We held a week. All our staff attended a half day session about our values. And you have probably seen our values around and about, have you, on the walls, in different places?
>
> Interviewer. Yes, I have had the pleasure of seeing them outside, yes.

Interviewee. So, we are really going to focus on those values. Last December, we organised the same sort of approach but not in a cinema this time. Everybody [went] on a half-day session about innovation, and [it was about] teaching everybody innovation techniques.

Some Social Enterprises have foregrounded equity in crafting their new organizational values. In the following extract, an employee discusses the key values of their social enterprise that are particularly relevant to equity. She describes how she is much more aware of the organization's values now than when she was in the NHS. She lays accent on how the values influence her day-to-day work as a manager to a much greater extent than they did before.

Interviewer. Just to talk briefly about values, how have your organizational values changed from the time you were a part of the NHS to becoming a social enterprise? And are there any values that are particularly salient for equity, for example, they might be around compassionate care, or?

Interviewee. That is one (smiles). That is one of the values. It is called compassionate care. We have very transparent values now, is how I would describe it. I think, maybe, they were sort of under the radar before. There was a sort of assumption that everyone in the world knows what your values are because you work for the NHS and, therefore, you must be caring, you know.

Interviewer. That is right.

Interviewee. (Smiles) Whereas, now, we have an organizational strategy which encompasses within it, um, the values of the organization, and those values apply to all staff...'Making their day' is one of the themes around that, and that is about offering compassionate care, about offering goal-oriented, you know, personalised care to people. So, it is also about being the best, so, making sure that staff are adequately trained and get support to do what they need to do, and they have, you know, regular performance reviews that are looking at what their needs are, and how they are working, you know, to support all of those kind of things. Then, there

are also financial ones but we won't talk about them. So, we have values, and those are on the website now, you know, publicised, so that is a real difference for me. So there are some around equity, around, you know, making their day. They are not directly written as that but yes.

Another interviewee described how their organization's values were given teeth, how they were embedded in specific operational practices to breathe life into them. As this person describes, this organization vigorously promotes and rigorously applies its values.

Now, we have a set of [name of social enterprise] values, and they are about innovation, and working together with partners, and being accountable, and we use those values as part of our performance development review, and the values are very much about being in the community, and recognizing the community. And we shout about that. We shout about that on [the company intranet], we shout about that in the weekly newsle...monthly newsletter, fairly frequent newsletter. We use that in our interviews with staff. We use, you now, value-based questions so that we are eliciting, you know, what is your experience of working together and winning together, what do you think is going to be key in [geographical location], who are going to be our partners, so, we are already making [new] staff [aware of the values], and I am more aware of just where I fit in the community.

In the next extract, the interviewee gives an example of how the different values of the Social Enterprise come together with the end result of promoting equity. It has been stated elsewhere that social enterprises give more autonomy to their staff, reduce bureaucracy and speed up decision-making. Those themes are illustrated in this example. These various organizational changes come together with the net effect of promoting equity.

Interviewee: We have Alcohol Enhanced Services. We have sixteen practices, not completely equitable, because it is not across the board, em, but in [geographical location], actually, what has come to light is that there is a cohort of Muslim

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patients who are drinking and actually got relatives who are aware and are feeling really quite isolated, and because the nurse is working in partnership with the doctor, they were able to discuss this, and we were able to go back to the carers, em, [name of support group], who are like the carer support group, and look at ways of taking that forward and, em, doing some consultation, so, the plan is for sort of 2015 that we are going to do like a consultation in relation to how we can make that easier for people to get support confidentially without feeling stigmatised, or, and, and support them.

A senior manager at a different social enterprise gave another example of values-driven change in her organization. This organization changed the contractor that supplied them with interpreters as it could not reliably provide enough interpreters for Eastern European languages. Not having an interpreter for a language spoken by a large number of service users was an equity issue. To address this equity gap, this Social Enterprise started employing its own bank interpreters. It also introduced British Sign Language training for its staff to make it easier for people with speech, language or communication difficulties to interact with staff. However, the comment by this manager that these changes might have happened anyway even if they were a part of the NHS suggests the difficulty of disentangling organizational changes happening after the transition to social enterprise and caution in interpreting results.

Interviewer: Are there any values which are directly or indirectly linked to the idea of equity?

Interviewee: I have thought of one. Actually, yes, because one of the services I manage is the interpreting service. So, we definitely have a policy of ensuring that we can provide somebody of that nationality to be able to help. So, that would either be face to face, if it needs to be or it would be a telephone interpreting service. We have, actually, already also, which is a really good point, employed our own bank interpreters because we were finding that the organization that we use couldn't provide Eastern European languages all the time because there is a lot of people coming into the country now. So, we've got our own bank of staff, and it's working really well.

Interviewer: Thank you. That is exactly what I was looking for because, quite clearly, if you don't have interpretation services, people can't access the services they need.

Interviewee: Exactly.

Interviewer: It might deter people from accessing the services they need.

Interviewee: And we need them to do that. And we can provide that. We are also looking at, let me think, right, the other thing we are doing at the moment is, there is gonna be some basic British sign language training for some of the reception staff across the organization. We have realised that if somebody comes to the desk and they are hard of hearing and find it difficult [to communicate], basic sort of signs or whatever, they will be taught...sign language basically, that it is used to help people understand, and they can be given really simple things like appointment, or a sign for appointment, and that is going to be rolled out to all the admin teams across [this social enterprise] so that they can all manage somebody who's got speech, language or communication problems.

Interviewer: These two initiatives, how have they come about? Are they in any way linked to your having become a social enterprise? Would these have taken place if you were in the NHS?

Interviewee: I think that it would have happened anyway. Certainly, the bank stuff has come about because we knew that we weren't getting the level of Eastern European languages, for example, that we needed. So, the leader of that service and myself said, 'Let's just try and recruit some people to the bank, and which is working really well. And I don't think we've ever had to say, 'No, I am sorry we can't provide an interpreter. And it is obviously cheap, so, let's do it ourselves, and which means that we can have more.

6.2.3. The Clear Assignment of Responsibility in the Organization for the Promotion of Equity

This section focuses on the role of a clear assignment of responsibility in the organization for the promotion of equity. The changes in Social Enterprises in this respect and the impacts on the equity-supportiveness of their organizational cultures are analysed.

The clear assignment of responsibility in the organization for the promotion of equity both affects, and reflects, how well an organization promotes equity. This often takes the form of a named Equalities Lead (Equality, Diversity or Inclusion Officer) or Equalities Office (or Team) to take ownership of equity-related issues and drive the equity agenda. The presence of such an individual, office or team often signals how seriously the senior management takes equity and how committed they are to it. As indicated in the Literature Review chapter, organizations that do not have Ethics Officers tend to have more ethical breaches. Similarly, organizations that do not have named Equality Leads are more likely to be prone to violations of equity. If staff don't know whose role it is to lead on equity, they may not know who to go to in order to resolve any equity-related issues. The lack of clear lines of accountability might lead to diffusion of responsibility. Not knowing who to turn to may deter staff from reporting concerns. Not making the identity of the Equalities Lead explicit and transparent to all staff, and leaving employees to guess who to approach, may cause delays in dealing with the issues.

It is worth noting that formal support structures for equity such as dedicated Equalities Leads are understandable in large organizations with thousands of employees, such as large NHS Trusts. NHS organizations are, typically, large organizations and, therefore, reasonably require a full-time person to coordinate and deal with equity issues in various departments. Social Enterprises, on the other hand, tend to be smaller organizations (from fifty to two thousand employees), so the appointment of an individual dedicated solely to the task of promoting equity may not always be feasible, especially as many Social Enterprises are trying to make do with fewer staff as part of their efficiency drives. In these smaller organizations, the role was often shared by an individual along with other responsibilities. For example, in one Social Enterprise, the Quality Manager (who dealt with complaints) or the Customer Engagement Manager, or the two together, dealt with any equity-related issues or patient complaints or incidents that they received. The Human Resources department was also sometimes involved in formal patient complaints.

At first glance, this suggests a reactive approach to equity in Social Enterprises rather than a pro-active one as in the NHS. The absence of a dedicated Equalities Lead and the simultaneous lack of clear assignment of responsibility in the organization for the promotion of equity did raise a red flag. It was a concern that it wasn't always clear to all interviewees who was in charge of promoting equity and who had ultimate responsibility for equity-related issues in the organization. One nurse manager echoed these concerns:

> Being able to be innovative helps you deliver better care, so I think you have an opportunity to be able to go, 'Actually, [we] are not going to just keep doing the same-old, same-old. We are gonna try and find these hard-to-reach people. There is a potential to do that. Being small, I think, constrains it because having a Health Equalities person who does that doesn't exist in our organization. That isn't gonna exist, I wouldn't have thought. So, it is always gonna fall on someone else's shoulders who has probably got seven hundred other things that they need to be doing as well. So, we are probably never gonna be as focused as potentially we could be.

This view was, however, countered by a nurse manager interviewee in another Social Enterprise. She argued that the absence of a named Equalities Lead in her Social Enterprise was not necessarily a cause for concern as equity was already a part of the professional medical values of clinicians and was also emphasized in their mandatory training. Further, she asserted that Equality Impact Assessments were carried out before major organizational decisions and these assessments evaluated the likely impacts of reconfigurations on protected groups. She went on to suggest that even though the previous NHS organisation where she worked had a named lead for Equalities, the person was just a figurehead. In the NHS, she was not performance-managed on how well she was promoting equity, nor was there any other meaningful influence of the Equalities Lead on her work. She was not aware of any initiatives by the Lead to promote equity. So, as far as she was concerned, there was a Lead for Equalities but they were largely ineffectual. In contrast, there was a pervasive sense within the Social

Enterprise that equity mattered, and that equity was a part of everybody's role, which made equity much more meaningful and impactful.

Interviewee: I haven't got a name of one person. In relation to Equality and Diversity, the Quality Team, [name of Quality Manager], would be the person I would go to. In the previous place where I worked [an NHS organization], I did know there was an Equality and Diversity manager. What did he do? I don't really know [laughs]. That was a tick-box. Is there an Equality and Diversity manager at [name of social enterprise]? I don't know. But, actually, I do know that we don't need one person. The fact that I don't know doesn't make me feel like it is an issue...In everything we do, we have to look at that anyway. Policies or guidelines always have to reflect that: how are we going to provide this service, and what are going to be the issues in relation to that? We've done a review of Shared Care and we know that it is not equitable. We've been able to raise that with the commissioners. But that's my responsibility as a Clinical Lead. It is all of our responsibility.

Interviewer. If it is everybody's responsibility, it is nobody's responsibility.

Interviewee: Yeah, but it is everyone's responsibility. The values actually highlight [that] it is all of our responsibility. The framework in relation to the guidelines, and the policies and procedures that we work to, they all reflect that. And how we roll them out is important. We have to give evidence in relation to that. So, it is managed in that way. As part of mandatory training, we have a commitment to keep ourselves updated. As part of our day to day work, absolutely a key part of what we do. As nurses, it is part of our health and social care assessment. So, it is sort of a framework for what we do rather than just someone sat in an office saying, 'I am an Equality and Diversity manager'. It is sort of how it feels compared to my previous work.

Interviewer. So, it is embedded in everything you do.

Interviewee: I think so.

Interviewer. Even though there isn't one individual tasked with...

Interviewee: There may be. I don't know that person if there is but it is not that I have thought, 'Oh, that's scary'.

Interviewer. Do I get the sense that you felt that this particular Equality and Diversity manager, their role was somewhat nominal and peripheral to, didn't really make much of a difference to what you did?

Interviewee: Yeah. I don't really know what they did. Because we had mandatory training but no one really managed it, as in, no one performance-managed [it], you have done training, you haven't...So I don't think that person even performance-managed the mandatory training because I would have remembered it. Like I say, the equity and diversity part of the policies just felt like a tick box exercise rather than something that you really thought about, used data to, what am I doing with this policy, where are we rolling that out, what are going to be the issues?

6.2.4. Performance Management, Incentive Systems, and Employment Terms and Conditions

In this section, the changes in the performance management and incentive systems, and employment terms and conditions, in Social Enterprises and the impacts on the equity-supportiveness of their organizational cultures are explored.

An insight that emerged from the analysis is that in the transition from NHS to Social Enterprise, employment terms and conditions appeared to have worsened, at least for some staff. This is likely to undermine staff morale. How staff are treated is a good indicator of how patients will be treated (The King's Fund, 2015; Addicott, 2011). If staff feel that they are being treated unfairly, then patients are likely to receive unfair treatment, too.

Interviewer: What have been the major changes?

Interviewee: Terms and conditions. The big ones are...incremental pay. I know a lot of staff have been put on static pays. There is quite a bit of uproar about weekend

working, unsociable hours, things like that. When I went to a meeting about it all, there was a few people who was unhappy about...the way you have been for a long time with the NHS, you get sort of rewards and benefits, and I think they have stopped quite a lot of that which increases your annual leave amounts and stuff like that. I know that's all changed.

Interviewer: So would you say that the changes are for the worse rather than for the better?

Interviewee: I think they were for the worse, with regards to terms and conditions.

However some Social Enterprises were offering more attractive terms to their employees than that offered by the market. Residential care workers are often paid very poorly, and sometimes, even below the minimum wage. A senior manager for a Social Enterprise described how they provided their Home Care workers more than the minimum wage. These staff were offered a living wage, and their package covered their travel time as well as their appointment time. Staff who receive fair compensation are more likely to treat patients fairly.

One nurse manager spoke of the challenges in attracting skilled personnel due to the relatively less attractive remuneration packages offered by Social Enterprises compared to the NHS. Resourcing has implications for equity as shortage of staff can put undue pressures on existing staff, pushing them towards taking short-term measures that compromise on quality as well as fairness and equity.

Interviewee: Recruitment was very challenging for a long period of time until the government made a decision that, actually, we could still offer the NHS pension. So, now we offer exactly the same terms and conditions as an NHS organization. But we had, probably, a two and a half year when we couldn't offer that to people, and it decimated recruitment. People just didn't want to come, because if you are, and especially for senior clinical staff, because they didn't want to lose final salary

pensions or, you know, the really good perks that you get, or lose annual leave and those kinds of things. So, that was a problem for us as an organization. It also, interestingly enough, increased our turnover. So, we lost a lot of staff. I don't know whether or not that is people jumping ship back into the bigger organizations where it felt safer in terms of those terms and conditions because we were on a bit of a rocky ship in terms of 'Are we going to get the pension ? Are we not? Will we keep it as existing members of staff' those kinds of things. I think a lot of people probably jumped because of that. One of the arguments for us bringing the pension back in was, I think, our turnover rate at one point was 25% or something. It was really high.

Interviewer. Not sustainable.

Interviewee: No. You just spent all your time training people to do their jobs and then they leave.

The Social Enterprises examined in this project reported making use of more effective reward systems to encourage desired behaviours in their employees. Reward systems are important in ensuring alignment between organizational aims and the behaviour of employees. Incentives shape behaviour (Fehr and Falk, 2002). Often, the behaviour that is rewarded is the one that gets practised, regardless of what the organizational values and aims require (Brickley et al., 1994; Jansen and Glinow, 1985; Worrell et al., 1985). For example, reward systems that encourage competition and individual performance work against stated organizational aims to promote collaboration and team work. As the case of Enron and other corporate scandals shows, misaligned incentive structures can conflict with stated organizational aims.

One change introduced by Social Enterprises to incentivise staff to perform better is by using immediate rewards rather than deferred rewards. The psychological literature suggests that immediate feedback and reinforcement is more motivating and helps sustains the desired behaviour better; later rewards are not so motivating (Fensterheim and Baer, 1998). By using better reward systems, social enterprises are encouraging and motivating staff to behave in more effective ways. Staff who feel valued and appreciated are likely to be more motivated to provide better, fairer care. A happy workforce is more likely to accept organizational changes

aimed at improving the quality and equity of care, and comply with organizational directives more whole-heartedly and with less resistance. The quote below illustrates an example of a Social Enterprise using immediate rewards with greater impact than deferred rewards.

> Because we are not an NHS organization, we do things differently, so we reward [differently]. We have almost like spot rewards for staff. That is not the term we use but it is reward vouchers, basically, for good work during the course of the year. So, if somebody has done something, we don't have to wait for a performance review to say, 'Well done. Here is your agenda for change increment, or whatever.' We can reward for a particular activity. The line manager can authorise a voucher for a range of supermarkets. We have a budget for that sort of thing, and that has gone down very well.

Another innovation by social enterprises in relation to reward systems is the use of private sector-style bonuses. As has been mentioned before, social enterprises make greater use than public sector organizations of private sector management models. One of the distinguishing features of social enterprises is the belief that private business practices can increase efficiency and financial discipline in public sector organizations (Teasdale, 2010; Westall, 2009). In this instance, a private sector incentive method has been applied in a public sector context, and, as the quote below shows, the effects have been positive.

> Interviewee. The other thing that came out of being a social enterprise and being our own business was that, last year, I think, it was, last year or the year before, we got bonuses, which again is, that is not a public sector model, kind of NHS usual model. They weren't massive or anything like that but, actually, everyone got a payment for the fact that we hit certain targets within our organization, and, so, because we did that we all got a bonus to say Thank You which was, again, a different way of, kind of rewarding staff that I hadn't experienced before. And I do believe that is part of the sort of, social enterprise, you know, that is the John Lewis kind of model.

6.2.5 Role of Leadership

In this section, the changes in the role of leadership in Social Enterprises and the impacts on the equity-supportiveness of their organizational cultures are considered.

The introduction of different, more effective leadership styles in social enterprises was another theme that emerged from the analysis of the interview data. It may be recollected that the role of leadership by the organization's top management is crucial in creating an environment within the organization which is supportive of, and promotes, equity (for example, by showing a commitment to equity, giving priority to equity, articulating and mobilising a clear philosophy of equity, providing resources and training, listening and responding to staff concerns and opinions about equity, etc.). Ways in which the top leadership can signal their support of equity include creating a dedicated, high-level task force to drive equity initiatives and take responsibility for equity-related issues; setting aside adequate resources specifically for initiatives that advance equity; and supporting equity-relevant data collection and research.

Public healthcare organizations like the NHS have traditionally been characterised by a hierarchical organizational structure and a command-and-control leadership style. Power and responsibility tend to be vested with those at the top (Addicott, 2011). Lower level functionaries are often reduced to obeying and carrying out instructions issued from the top. Social enterprises, in contrast, are pioneering a more participatory, democratic, and inclusive approach (Addicott, 2011). They are devolving power and responsibility to the lower levels. As the extract below shows, social enterprises are encouraging front-line staff to take on roles of leadership. Thereby, social enterprises are fostering greater staff engagement with organizational decisions (Addicott, 2011). They are getting more buy-in from staff and this is resulting in more effective implementation of policies made at Board levels on the front line.

This is a radically different approach that requires trusting people at lower organizational levels to do the right thing and encouraging them to use their initiative to solve problems. There is also a greater emphasis within the new leadership and management style on collaborative working and teamwork. The changes in leadership style by those at the pinnacle of the organizational hierarchy and the efforts to develop grass-roots leaderships have resulted in greater equity in care provision. Front line staff who see the equity problems clearly due to their daily interaction with patients have the authority and the resources to initiate action to address inequity, and the confidence to challenge poor care.

Interviewee. So, I think that, coupled with the freedom of, perhaps, being in a business and having to change, because we have to be successful, there isn't anyone to save us, there is also this kind of leading approach now, so developing leadership within the organization and giving people the ability to develop those skills, challenge the norm, but doing it in a way that is, you know, in an appropriate way. So, I think those two things are kind of run together and developing some success. Again, it is still an unwieldy beast generally, and a lot of staff are used to a hierarchical leadership approach, you know, manager says, 'Do', you do it, or you don't do it, you know, but a very limited amount of engagement in what we are doing, how we are going to develop things. But, you know, over the last year, I have been able to do things like bring together the performance team, the financial team, human resources, business development, and with that we are just about to set off with this as a plan...with the team, the staff, actually look at, what are we doing as a team, what are our priorities, what are our actions, how are we going to develop those over the next year, what are the things that the organization needs us to do that are important, what are the things we would like to do if we could.

So, instead of the organization going, 'You have got to do seven audits on this, and you have got to do that, and it is all pointless, but we have to tick lots of boxes. The aim is that that is going to be driven by them with the support of information from corporate services to actually drive the service forward and do something that is useful which, then, will impact on patient care because you have better clinical service because you are auditing what you are doing properly, and you are actually

engaged in it as a process. It means that, then, you look where the issues are, and, then you deal with them, and, you know, all of that kind of stuff. I kind of changed to the cycle of 'me saying, they do' and they just doing it or not doing it, but not really engaging in it, and is that because we are a social enterprise, is it because leadership has become better on the agenda and we have become suddenly aware that if we don't empower staff, Francis kind of awful things happen, like Staffordshire, do you know what I mean. So, I think that that is probably quite a lot of strands that run through these changes that make us able to do things differently.

The quote above also illustrates that while social enterprises seem to have taken the lead in developing alternative, more democratic leadership styles, this is also related to national-level policy drivers and changes in the wider healthcare landscape, for example, the Mid-Staffordshire scandal and the Francis Report. So, many NHS organizations, too, may be moving towards this model or, perhaps, may be contemplating the adoption of similar models. The King's Fund report on collective leadership emphasized the need for developing leaders at all levels of the organization as a necessity for improving the standard of care and addressing problems of poor care in times of constrained financial resources (West et al., 2014).

One interviewee gave a detailed example of how social enterprises were challenging the traditional structure of power within the NHS where power rested with doctors and decisions were typically made by them, with nurses expected to carry out their instructions. Social enterprises are empowering nurses and enabling them to have a greater say in important organizational decisions, especially, as they relate to how services are designed and delivered.

Interviewee. I have been a real believer in nurse prescribers, and in my last job, that was sort of poo-poohed really, sort of pushed down. The medical structure had a real vested interest not to support that. And there wasn't really much way to influence whereas here we have been able to look at that and, actually, we have been able to grow that as a service model, and coming up to the tender that is something we are going to be, so, that is a small example. I am, I am involved in operational and strategic, em, you know, ways of providing services. We are

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looking at a new service model for alcohol...there is equity, for example, the nurses currently, because of the way they work, are only able to see certain people and, actually, so, a lot of people don't get access to clinical input, so, we are re-modelling, and I have been able to have an active part in that rather than being dictated to.

A related sub-theme that came out is that the leadership in social enterprises is better attuned to input from clinical staff. This is critical because clinical staff have direct contact and interaction with patients and service users and, are, therefore, likely to have the best knowledge of their needs and requirements. Clinicians are also likely to know about gaps in provision where the organization fails the needs of those it serves. They are likely to be aware of organizational shortcomings and their input is critical in re-designing and re-configuring services to better meet the needs of patients and service users. As the quote below shows, the leadership in social enterprises is doing a better job of listening and responding to the concerns and opinions of clinical staff.

Interviewee. I think the nature of leadership within Social Enterprises and the fact that it has, I think, moved to being more bottom-up than top-down means that they are more able to listen to clinicians, and what clinicians' issues are, and clinicians are often quite aware of where there are gaps in services and that they, you know, they are quite good at highlighting those kind of things. So, I think that having that ability to, you know, bring it up to the eyes and ears of the senior leaders means that it can become more relevant to them.

Another organizational change that supports equity is that the top leadership in social enterprises is much more visible and accessible. This may be partly a function of size (social enterprises being much smaller organizations than NHS organizations) and better use of technology. However, it also points to a different leadership style within social enterprises where top management are not completely removed from the daily lives of most staff. Social enterprise interviewees talked about how when they were in the NHS, top management inhabited a different sphere, and there was little contact between them.

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The reduction of distance and closer interaction between top management and front-line staff in social enterprises is important because it means that top management are more likely to get accurate information from those on the ground, and get this information quicker. It means that they can act more quickly on this information and make the necessary changes sooner. It means less likelihood of information being filtered and distorted as it goes up the organizational chain, where managers pass on information selectively or subtly distort it to fit what their superiors would like to hear. It also means that staff throughout the organization are aware of strategies being formulated at the highest level. They know where the organization is heading. There is greater clarity about organizational aims and strategies. This can be motivating for staff and also useful in tweaking and fine-tuning high-level policies and services at the front-line, which people on the ground are uniquely equipped to do. Communication is likely to flow more smoothly; there is less likelihood of misunderstanding. The quote below illustrates how a social enterprise staff member felt that she was a lot closer to the organization's top leadership.

> Interviewee. I think the management team in here are more visible. They are more visible from an away day. We have frequent [meetings]...in the Health and Wellbeing department we have once...twice a year we have a week. We get together and, you know, senior managers are there, giving us updates about developments and what the issues are, and what is happening in, with the wider sort of NHS and commissioning structure. So, they are definitely, definitely more visible. They are visible and more easily to communicate with because of our digital technology...we have got like a learning wall where we can put in ideas in relation to the tender, and that is just really quick and timely, and someone, you can respond and like as soon as you read it, and [the CEO] is part of that as well, Chief Exec. So, for me, everything just seems more visible in this structure compared to how it was. I knew who my Assistant Director was. Did I know the people above? Did they say hello to you as you walked into your office ? No.

> Interviewer. Are you talking about when you were within the NHS?

> Interviewee. Yeah, yeah. I can't comment for what it was like here when it was the NHS but for this social enterprise, people will acknowledge you.

Interviewer. So, there is far less distance between where you are and senior management.

Interviewee. Absolutely. That is absolutely key, which, then, supports all of the other things that lead to all the other things.

Another interviewee commented on how top leadership was not only more accessible, but also more approachable and supportive.

Interviewee. My manager is just really accessible, within reason, of course, you know. It is like the nurses, if they are in clinics, you can't keep pestering them, the same with me, and the same with [another operational manager]. But everything is so much more accessible.

Interviewer. Great. Thank you. So, you are saying that top management are not only more visible, but also a lot more accessible, and that getting their support, getting their sign-offs, getting their approvals is a lot easier than it would be in the NHS and that, I suppose, has an effect on anything you wish to do.

Interviewee. Absolutely. Yeah.

Another interviewee expressed a similar view and highlighted some of the differences between social enterprises and the NHS is respect of the accessibility of the top leadership.

Interviewee. Top management [emphasis]. You can email them. You can pick the phone up. You can arrange to go and have a meeting with them. They are very approachable. They are there for you when you want them to be there.

Interviewer. Right. And...

Interviewee. And that is not...[laughs] that is not...in the NHS it is slightly different. You, you probably wouldn't be able to get in touch with them.

Interviewer. Right.

Interviewee. With [the CEO of the current organization], you could, like, send him an email and he will reply back to you. If you asked to have a meeting with him, and you would have that meeting. I know that happens because I have had it with him.

Interviewer. So, there is a major difference between...

Interviewee. Yeah, major difference. Very supportive.

The greater visibility and accessibility of the seniormost leadership has several important implications. Firstly, it establishes the tone of the leadership style through the ranks. Middle managers emulate the leadership style of their superiors. Thus, a democratic and participatory leadership style at the very top cascades throughout the organization. Encouraging leadership throughout the organization has several potential benefits – improving staff productivity, increasing alignment with the organization's strategic direction, improving staff morale, etc. It may also encourage staff to treat patients in a more equal and inclusive way and reduce the power imbalance between caregivers and the recipients of care.

Interviewer. Has this reduction in the distance between where you are and senior management resulted in more support for your ideas? Has it made your job easier?

Interviewee: My job is so much easier. Because that is the culture, as a manager, it is really important for me to be like that with the team as well because nothing else is acceptable. Our meetings are really important but our one-to-one informal meetings with the team [are, too]. It might not be every four weeks but, at least, once every few months we meet up, we have a coffee, we talk about things, what's going on, what's your point of view. People see that, and are able to feel that they have influence. It's not just a coffee and then nothing happens. It is a coffee and, oh yes, that is an important bit, and we can talk about that at the meeting, do you want to raise that at the meeting? So, the culture in here is very much pro that.

Some Social Enterprise staff acknowledged that the mainstreaming of the new leadership model was a work in progress. In the extract below, a senior manager talks about the fact that some staff still aren't on board with the new approach to leading and managing, and that much work remains to be done to harness the full potential of a more democratic leadership style.

> Interviewee: I think if we have got one thing still to do, it is try and get the middle bit. You will probably find this in lots of places. It is finding the middle management, the route through that. The senior folks have got a clear understanding. The people at the front-line are beginning to use some of that, and will engage on projects like, 'Let's develop a clinical [model].' How do we do that? Well, we are not going to do it. We need our front-line staff to do that, so, we involve them. But sometimes it is the behaviours of the middle management that can block some of the things coming up as well. And there clearly is work pressure and workload, some of the things behind that as well. But trying to get our middle management, in any organization, whether it is NHS or social enterprise...it is not a social enterprise thing, but if you are claiming that in a social enterprise, that is what you do, it just becomes a more important challenge to face. So, we are running leadership development sessions for our middle managers to see the potential from that.

6.2.6. Bureaucracy and Ease of Decision-making

In this section, the changes in the ease of decision-making and the reduction in bureaucracy in Social Enterprises and the impacts on the equity-supportiveness of their organizational cultures are discussed.

A distinct theme that emerged during the analysis is that decision-making was a lot easier and faster in Social Enterprises (in terms of requiring approval from fewer people, requiring less

paperwork, etc.). Easier and speedier decision-making has clear implications for the promotion of equity as it enables staff to make decisions that advance equity easily and quickly. Given the fast-moving nature of the healthcare industry, it also has significant implications for quality of clinical care. The NHS has been criticized for being slow in changing. Many ex-NHS staff now working in Social Enterprises expressed frustration with the slow process of decision-making within the NHS, the difficulty of getting decisions made, and the resulting de-motivation and demoralisation.

In contrast, social enterprises have made rapid strides in removing some of the bureaucracy and red tape that slowed down the NHS. This has energized employees, encouraged staff to take the initiative and stimulated innovation. One of the main reasons cited by interviewees for becoming a social enterprise was 'the opportunity to be fleeter of foot, less bureaucratic...We can make decisions much quicker, still with due diligence, still with risk management in mind, but quicker.'

Social Enterprise staff described the different kinds of obstacles that they experienced as NHS employees in trying out new ideas. These ranged from the need to obtain approvals from a number of committees to rigid organizational policies about who to purchase supplies and equipment from, etc. One employee described the NHS as a giant rolling wheel whose momentum was unstoppable; to try to change its direction was perceived as being extremely challenging. In contrast, she describes the energy and the excitement of being able to change things in a social enterprise: 'The NHS has always felt like a juggernaut that is travelling in this direction, and to turn it, bend it even is like a nightmare, you know, whereas I always feel [that] businesses, the ones that survive and are successful are innovative and they change and they modify and they move and those kind of things, you know. The NHS fails mostly because we are just *plodding on* [emphasized this with drowsy facial expression], doing, you know. Social enterprises, I think, do give you the freedom to challenge more around that, and kind of go, 'I actually want to do something different; let's find a different model, perhaps.'

One nurse manager contrasted her frustration with the bureaucratic machinery of the NHS with the relative ease of making decisions in the social enterprise. She attributed

the red tape and the bureaucracy in the NHS to the loss of control and decision-making powers over internal matters in the NHS. She rued the fact that decision-making about local issues was no longer within the control of the organization.

Ease of decision-making is an important instrumental factor for equity. It allows opportunities and threats to be identified and appropriate actions to be taken promptly to take advantage of the opportunities and counter the threats. If staff identify an inequitable situation but feel that their hands are tied and are consequently paralysed into inaction, then the problem continues to fester. On the other hand, if staff are able to take a decision to change something quickly, then the inequitable situation can be rectified promptly and decisively, to the satisfaction and advantage of both the clinical staff and the patient. In the extract below, a Social Enterprise interviewee gives an example of how faster decision-making had contributed to the provision of more equitable care.

One of the nurses' ideas was to, we have a specialist drug service, a drug and alcohol service, and one of the nurses expressed an idea that could we use one of the local health centres, now in the NHS. My view is that to get to that point you would have to go through so many meetings and so much ratification, it was just, it added barriers, and you probably gave up along the way. Well, actually, we were able to work with our non-staff providers. Yes, we had to make sure that we had done a risk assessment for the room, and, but the process was sort of done and dusted within a few months, whereas, you know, that sort of change of how you provide a service just wouldn't have (smiles) worked so quickly. So, there is a few examples but it is just that, some more local accountability and just having it in-house almost that the NHS has lost.

So, that is sort of a small example of innovation and working together, and the other one is being accountable, and that nurse hasn't just found that information through, 'Actually, I really don't care what is happening'. That happens in the NHS a lot because they think, well, there is no point saying anything because nobody will listen, and, actually, if they do say something, it will take months and months and years and years to change it, so, I won't bother, whereas this nurse knows, she can

discuss it with her GP, she can discuss it with me in supervision, and then we can discuss it with our partners and then we can do something about it. So then you feel better, don't you, because you feel like you are making a change.

In relation to the reduction of bureaucracy, one Social Enterprise interviewee described the challenges of ordering goods and equipment in the NHS. NHS organizational policies about preferred providers tied staff to certain suppliers. The intention was, of course, to generate economies of scale by consolidating purchases. However, as this interviewee explained, this was not always the most cost-effective option. In a time of extremely tight budgets and acute financial pressures, this was an avoidable waste. It also meant a lack of flexibility to obtain equipment from other suppliers whose products were better suited to the needs of the staff and the patients who were going to use them. Not having the right equipment hamstrung staff and limited their ability to perform their roles to the best of their ability.

Interviewee: I mean, from a very simple perspective, just the ordering of goods, em, obviously, we have preferred providers,...you want to buy a piece of equipment and it has to be from one set place, and from a manager's perspective, there is a cost saving to be had. I can go and look anywhere and order equipment. I can go and buy something and get that claimed back. That might seem not very big but, actually, that is sort of almost core to it, that you can't even make a decision in the NHS about what equipment you want. It is this or nothing.

The interviewee mentioned above suggested some of the reasons for the lack of operational flexibility in the NHS. It was partly, she thought, due to procurement decisions requiring approval from several members of staff, due to the requirements imposed by NHS commissioners on providers to adhere closely to the specifications of contracts. The mindset of sticking zealously to the minutiae of service specifications made decision-making slow and cumbersome and bred a culture of apathy, passivity and learned helplessness. She said that the situation was getting better as commissioners were allowing providers more leeway in determining the best ways of achieving the outcomes.

Interviewee: The red tape. You can't do this unless it has been here, here, gone up to that panel. You can't buy that new equipment because that is not on the list. I think, in the NHS, historically, the culture is that they think that they can't make changes, that it is around what the service spec says, and that is only what will do, you know, the service spec says, 'We will do this'. And I think that commissioners have been partly to blame for that. Commissioners have thought that they are part of the provider service, and I think that is where it is changing. That is why the NHS is changing a little bit. Suddenly, the service specs are a bit more general, so, it is that higher-level outcomes, and you then have to find your own way of achieving those outcomes. I think Social Enterprises have cottoned on to that quicker, perhaps, but the NHS is catching up on that, otherwise they are going to lose services and contracts...In Substance Misuse it has been very much about the bigger outcomes and delegation of 'These are the outcomes we want, do it in the best way'...

Interviewer. So, they set the targets but they leave operational flexibility and autonomy to you. You decide how you want to provide the service to achieve those outcomes.

Interviewee: So, we have the flexibility to be able to look at those outcomes and say, actually, we can achieve this by this because we've got this data. We know this is a fact. We know these are the issues, so, we are going to look at new ways of working. I've had in this job flexibility to do that which I didn't have in Substance Misuse service in my previous job. It was, well, we've been employed to provide this GP practice service, and that is what we will do.

Another cause of the stifling bureaucracy in the NHS that she identified was the sense of complacency in the NHS. The NHS, she asserted, had always lived a protected, sheltered life. Due to its political importance and sensitivity, governments had always bailed out poorly

performing NHS organizations. Since financial accountability was lacking, poor practices and inefficient ways of working had persisted in the NHS. Because Social Enterprises could not rely on similar beneficence and patronage from the government, they did not have the luxury of tolerating these limitations and had worked hard to eliminate the inefficiencies. They had to be much more sensitive to and watchful of their finances. The interviewee also argued that the separation of the clinical and financial roles in the NHS had contributed to the lack of financial savvy and cost-consciousness. In the social enterprise, in contrast, all staff were involved much more closely with the finances of the organization and were more finely attuned to the cost dimension of decisions. Staff realised the need to act and change quickly to compete in the marketplace. Therefore, there was less tolerance of bureaucracy and less resistance to change.

Interviewer. Was there something different about the NHS that resulted in this greater inertia and resistance to change? Was it a greater sense of complacency?

Interviewee: Absolutely [said this with a lot of emphasis]. That's the word. Complacency. They've always had the money. Nobody actually is really interested in what the outcomes are. Nobody really knows where that money comes from and what that medicines budget is... In the NHS, you are so far removed from all of that. Front-line staff just do the job rather than think about the job...There is no hands-on, they are not involved in their budgets, they don't understand what the consequences might be, and, actually, there is never any consequence...Whereas in such a smaller social enterprise, we've to know those things. We've to know our budget lines. We need to know where that money is coming from. If we've got these ideas that we want [to implement], probably the pot of money is not going to increase, so, we want to find the best way of using it so that we can re-invest some of it or use it more effectively. And because everybody is involved in everything, they are also involved in the long term outcomes as well, and the recognition of what we have to do to achieve them.

One interviewee suggested that the bureaucracy in the NHS may be a function of size and the complexity of services, and that some of the advantages of the Social Enterprise model may have stemmed from their being small, independent organizations. However, another

interviewee argued that the lethargy and sluggishness of the lumbering giant NHS and the relative nimbleness of social enterprises could not be reduced to the differences in size. She said that it was not so much the difference in size as the culture and the mindset. Responsibility and accountability for results, she said, were missing in the NHS and that came down to the sense of complacency.

Interviewee: No, I don't know whether it is just size. I think it is, because, actually, [name of social enterprise] is a big community service, it is culture, it is culture. It is involving staff in innovation and improvement but, then, with that comes responsibility and accountability...They are just small little things, but, actually, with all of this lovely progress and empowerment comes responsibility and accountability, and that is just not there in the NHS. People are tossing it off (smiles), and I love the NHS. Do I not want an NHS? Absolutely, I don't, you know, it fills me with horror but I also see poor practice within the NHS that would not be stood for here, in this social enterprise, and that goes back to your complacency. That's the word. And it breaks my heart to say it, because I have been in the NHS thirty years. But you get to a point when you [are] thinking, 'Gosh, if I [have] another seven or eight years left of my NHS career, do I want to spend it in this *monstrosity*, well, no, I didn't want to, and, so, I left.

In contrast, however, a senior manager in the same social enterprise attributed their greater agility to being a smaller organization. Along with being smaller, they had a flatter organizational hierarchy and this meant speedier flow of information all around, which facilitated faster decision-making. The extracts below from two interviewees exemplify how their social enterprises were demonstrating the virtues of being small.

Extract 1

I feel like I have more ability to be able to make decisions, do things, talk to people, involve stakeholders. I do feel that, em, in a different way than, perhaps, I did before. I think as well, being a social enterprise, because we are not a Foundation

Trust, we are not big, is the general gist of what that means, as a small organization, we are all very close to each other. So, it means that decision-making is relatively easy, and that there is always somebody that you can have a conversation with about something who, actually, is able to make a decision. You are not far away from the Board, is how I would describe it. So, it means that if you have got an idea, people kind of embrace it and want to run with it, and in a different way. [A decision] hasn't got to go through fifteen committees before anyone even absorbs the idea. And that might be just because we are small, perhaps, in that, you know, I think I am three positions away from a Board person. In a secondary care organization, I would be a nobody, if that makes sense.

Extract 2

I think that we are a relatively flat organization in terms of structure, so, ideas can come up through the organization. The business unit structure means that our workforce have got a clear link into senior management, and senior management have got a clear link into Board, so, that is relatively straight-forward.

Social enterprises have succeeded in removing a lot of the baggage that slowed down the NHS. This agility gives social enterprises a decided competitive advantage as they are able to respond to regulatory and industry changes faster. It also enables them to innovate and move ahead. A social enterprise employee spoke of how an important decision about a major investment in technology was made within a much shorter timespan in their organization. The interviewee described how a decision to start a mentorship scheme for school-goers was implemented without the attendant delays, indecision and buck-passing that were typical of the NHS. A similar decision within the NHS would have typically taken much longer. He said. The three examples quoted in the extracts that follow not only demonstrate the innovativeness of social enterprises, they also show how they are investing in the local economy, regenerating the local economy and the community and adding extra social value.

Going back to the decision-making, [we are making] decisions in a timely way in a measured but reasonably swift way. I guess, [name of Team Leader, another interviewee from the organization] will have talked about technology. Big decision that we made almost two years ago, was to invest, over five years, twelve million pounds in our IT, our laptops, the software on the laptops, the technology to go with that to make, what was already a mobile workforce a more effectively mobile workforce, to communicate via Link and all of those sorts of things. Those Board decisions were made with a lot of rigour but our Board made them without months and months of preliminary negotiations with other stakeholders in this process. We were able to crack on and get it done after rigorous discussions. So, I think that is another example of the difference between us and an NHS organization, quite frankly.

So, in an NHS organization, if you wanted to set up a mentorship scheme with a school, that would have had to have gone to a couple of committees, might not go to Board, it wouldn't necessarily be a Board decision, but it would have to have gone to a couple of committees to get that going. We did it within a management team. We just said, 'Right. We can see a role for this. We are gonna set up some mentorships. We are gonna have ten of our staff mentoring ten students from [a particular] school in, in [geographical place] in the sixth form who are doing health and social care. We like the idea. We are gonna do it.' We done it. It has worked. It has been a great success.

Setting up out Home Care business, the subsidiary, was done within a matter of very few months from decision to delivery...I think we are good and getting even better at giving people responsibility and accountability to, to get on and make decisions.

You can imagine again, that [in the NHS it] would have gone through a whole HR process of, of various committees, and waiting for an answer from them. We talked to our HR team about it, we thought about what the risks were and what the benefits

were, we worked out why we needed to mitigate some of those risks, and we got on and did it.

The extract above sums up the mindset of social enterprises of 'making decisions quickly, making decisions without bureaucracy, and in a managed but timely, very timely fashion'. The researcher can attest to this. In terms of getting ethical approval, it was much easier to get approval from social enterprises than from NHS organizations. Whereas obtaining R&D approval from NHS organizations took months, the process was completed within weeks in social enterprises. Another social enterprise interviewee talked about his organization took a different approach to risk management from the NHS, and how this had made risk assessment and management not only more effective, but also quicker.

One of the other big differences, is, you said, about fundamental, lasting change and differences, is how the NHS approaches risk-management and Board Assurance and assurance processes. I joined six months before we became a social enterprise. I used to work for the Audit Commission. So, I used to do external audit of NHS organizations and I was the national lead for risk management with the Audit Commission. I saw lots of risk management going on in the public sector, local government and in health, and I recognised that it was a huge, bureaucratic process that didn't really address, get to grips with what the real risks were. The real risks were often identified through quite a bureaucratic process but, then, nothing happened to them anyway, so, kind of, why bother if you are not going to do something about them?

Also, if your focus is solely on risk, you don't think about what the opportunities are, and you don't think what the successes are, and I think it is important to celebrate success, so, we have introduced something called a KORS - Key Opportunities, Risks and Successes. We have a corporate, a strategic risk register [which] has replaced our approach to risk management so that...all of our governance process is channelled through a KORS process whereby these key things get drawn out from a meeting, and from a team, and get escalated up through

the organization, so, you have got the far more less bureaucratic and vibrant sort of approach to managing risk.

Things like the KORS are brief...We will still take minutes from meetings but normally, let's say, in a structure in the NHS, you would have the minutes from that meeting going up to that meeting, going up to that meeting, and they will be expected to be reviewed. Well, what happens is, yes, the minutes go up, but the KORS goes up, and the KORS is the thing that is, then, reviewed in the meeting, so that you are just looking at one sheet of paper. You can see what the key messages are from that meeting. If you want to go into more detail, you can but you are not reviewing another set of minutes, so, there is an example, if you like, of cutting down bureaucracy.

6.2.7. Autonomy and Empowerment

In this section, the changes in the autonomy and empowerment of frontline clinical staff in Social Enterprises and the impacts on the equity-supportiveness of their organizational cultures are examined.

A theme that was identified in the analysis is that social enterprises give their staff more autonomy over their work. They give staff more freedom to make decisions on their own and more influence to shape the way services are delivered . This is particularly important as there has been a growing recognition within policy circles that clinical staff know the needs of patients best, therefore, empowering them to shape how services are delivered is critical to improving the quality of care. Becoming clinician-led has become the ideal to which many healthcare organizations aspire. As the extracts in this section show, Social Enterprises appear to be moving closer to realizing this ideal than NHS organizations.

Traditional state-provided welfare services have been criticized for providing a standardised, one-size-fits-all service and for ignoring the differing, unique needs of service users. Social enterprises are challenging this norm by supporting their staff to personalise and tailor services to respond in a sensitive and equitable manner to the individual needs and preferences of patients (National Audit Office, 2011; Directorate of Commissioning and System Management and Social Enterprise Unit, 2008). An important factor in this change has been giving clinicians a much bigger role in designing services. One interviewee described the extensive role that clinicians had played in the development of their clinical model: 'They have been heavily involved in the development of our new clinical model that is part of our bid. So, front-line clinicians have developed that, not a set of managers somewhere remotely.' The following extracts from two interviewees illustrate the greater sense of autonomy that staff in social enterprises are experiencing and how it is contributing to their motivation, self-confidence, and estimate of their professional capabilities.

Extract 1:

Interviewee: There is an ability to challenge a lot of what has been the usual ways of doing things because of the fact that there is more autonomy and more ability to be flexible around the way you deliver things. You can be a little bit more business-minded about things. You can challenge ingrained behaviours, the 'we have always done it this way' kind of approach... And it has been a change in my thinking from the, well, 'We get X amount of money and we will always put so and so into that to do it, and that is what we have always done, so, it will be that band. And, now, I think much more broadly around what are the skills and competencies that you need to do that, how am I to get people like that, where am I to get them from, who is out there, how can we poach them from somewhere else?

One good example of what I did is that I interviewed for a highly specialist role. I had two staff that I thought were brilliant, but only one post. I knew that another post was gonna come up at a different point, so, I went to the Director of Operations and said, 'Look, what I would really like to do is I would like to go and risk and get both these people. They are both really good. These people don't grow on trees.

I need these people. I know this job is gonna come up. It will be three to six months probably till it comes up, so, it is a risk. Can I do it? Yeah. Brill. Job done. Right. Offered the post. Person is coming from [a slightly far-off place], so, she is like, oonh, well, coming on to the new conditions, not very happy about that. What can you do? So, well, I can't give you an NHS pension at the moment but we are working on that, and I am hopeful. What I will do is I will offer you an extra increment to make it up. Completely different way of working to what I am used to.

Interviewer. I see what you mean.

Interviewee: Do you know what I mean? So, suddenly, you have become like a business, and, kind of, go, I really want you. What can I do to get you? So, instead of the normal, which is 'You are a Band 7, you start on this point, and no matter what happens in the world, you will start on that point, however much we want you.' That's where I have come from. That was always the way. Actually, you have got some autonomy here to go, actually, I really want this person. This is worth, you know, £500 a year. Let's not get into a twist about how much it is in the scheme of the world. And, actually, we got that person. She has come. Brilliant. Happy days in my world. I wouldn't have got her if I hadn't had that autonomy to be able to do that. That for me is a real change in the way we do things. We don't do it to everybody, obviously. You gotta really want [that person] but also we have also been able to do things like incentivise posts that are difficult to recruit to by offering extra payment or whatever. Again, I didn't ever see that in the clunky NHS that I worked in. It was much more fixed in its processes of doing things, couldn't see beyond.

Extract 2:

Interviewer. It appears from that example that the ideal of empowering front-line clinical professionals and giving them a meaningful voice in decisions about how to provide services is being realised within [name of social enterprise].

Interviewee. Yeah, yeah, definitely is in the Substance Misuse service, it is. I don't think there is a particular name to it but that is just what people do, you know,

because they want to be involved in that...We had done some preparatory work and now the nurse and the Lifeline worker have been able to say, actually, we want to change this. Would you be happy for us to amend this cluster work ? I said, 'Yeah, you know, keep the original one but, yeah, do your draft and, then, at the next Working Group, we can re-discuss it.' So they are actively involved in that, and that could be in the tender. And they are driving it, not me. I have set a tone, and I have put a draft together but it is actually more about other people adding to it rather than me just saying, 'This is the final document; we are all going to start this next week'. It is a much safer way, isn't it, because, you know peer-led support is often more influential than (smiles) just support. So, if you have got a key nurse on board, and actively driving it, you are more likely to be able to implement it in a team way. That doesn't happen in the NHS, or in the NHS I worked in. It was like, 'This is what you are doing next week'. And you will be like, 'What about this, and what about that?' 'Sorry, but that is what you are doing.'

Interviewer. It was a lot more rigid.

Interviewee. Yeah, look, this is the real world. Even in social enterprise there are times where you have to do what you have to do but you might feel less disillusioned by that if, actually, you know for the most part you have got a lot of influence.

A nurse manager spoke about one of her charges, a nurse, who, because of the culture of autonomy and empowerment within the social enterprise, felt supported in taking initiatives that helped drive up the standard of care, improved patient experience and equity. Examples like this suggest that trusting staff, giving them greater responsibility and supporting them in carrying out their ideas has helped liberate the dormant entrepreneurial energies and instincts of staff. This has had positive implications for quality of care and equity.

Interviewee: There is another one, be inspirational. And another example has been in relation to the use of Facebook. We have one nurse who has put a huge amount of work into that. The Likes are increasing, and the feedback has been really positive from commissioners and patients. But also because she is just feeling really

good because she has influence, and she is really good and she is respected, she takes it further in other areas so, she has set up a peer support group for GPs where they are all able to come and talk about cases. There might be one Substance Misuse Specialist GP in a practice and they are on their own whereas now they can meet with all the other practices once every three months. She has really put effort into that, sourced funding for it, organises tea. You wouldn't get that happening in the NHS. It would be stamped on. Sorry. Have I go any evidence for that? I don't know but that is how it feels.

Interviewer: Do you think this meeting of GPs might have implications for equity?

Interviewee: Absolutely. One of the last discussion points was around [a particular drug]. Some practices are prescribing far too much of it - we've been made aware of this by the clinical commissioning group QOF audits that they do – but, actually, they're really, really struggling, and they are prescribing too much, and some of it is going out into the streets. Another practice is not prescribing at all, and actually some patients do need it. So, by sitting together they are able to look at all the research, all the Cochrane reviews, and make a decision on, actually, it is ok to prescribe it sometimes as long they are within these boundaries and it is not forever, and it is safe to say no to somebody and it is safe to say yes. So, suddenly, the management of anxiety, and short-term crisis anxiety, or alcohol withdrawal might be better managed across [local place] just because six GPs have got together and have shared some ideas and looked at research...And I don't do any of that. The nurse leads all of that with one of our doctors, and that is great, isn't it?

6.2.8. Extent of Employee Involvement in Strategic Decision-making

In this section, the changes in the degree to which employees are involved in strategic decision-making in Social Enterprises and the impacts on the equity-supportiveness of their organizational cultures are examined.

An important finding from the analysis was that social enterprises were involving staff, especially, front-line staff more in strategic decision-making. An important or strategic decision is one about the long-term direction, goals, or values of the organization, or about appropriate ways to invest significant financial and human resources. Employee involvement in strategic decision-making has relevance for the promotion of equity as it is front-line employees for whom equity is most salient due to their daily interactions with patients. Managers further up the organizational chain tend to be more distant from patients and their issues. As middle and senior managers are not confronted with equity issues in as immediate and direct a way as front-line staff, equity is likely to be a bit more abstract and less of a pressing, live issue for them. Thus, the involvement of front-line employees in strategic decision-making has the potential to ensure that equity remains a priority in decisions that affect the strategic direction of the organization.

The involvement of employees at all levels in strategic decision-making is an important element of the social enterprise model and one of its strengths (The King's Fund, 2015; Addicott, 2011). One interviewee stated that one of the main reasons why they spun out as a social enterprise was 'to get our staff colleagues more involved, in a very different way to a traditional NHS.' The idea of involving the rank and file in the running of the organization was put into practice in different ways in different Social Enterprises. One healthcare social enterprise had members of staff, service users and carers on its board and they had equal voting rights. Some social enterprises did it through the allotment of an equal number of shares to all employees. This was meant to signify equal power and equal ownership. It gave meaning to the idea of an *employee-owned* organization or a *mutual*, i.e., a mutually owned organization (Cabinet Office Mutuals Team, 2016). The quote below suggests how one social enterprise is implementing the idea of employee ownership or *mutuality*.

> Interviewee. If it [a social enterprise] is in the middle ground [between the public and private sectors], which, I would suggest it is, the difference between us and a public sector organization is that most of our employees are shareholders. So they [have] one share in our business each. Whether you are a Director or a clinical assistant, physiotherapist, you have one share. I think that its root is there. That is its root.

One interviewee commented on how the idea of employee involvement was actualized through the creation of specific mechanisms such as Staff Councils. These are bodies comprised of members of staff from all levels of the organizations. Staff can put themselves forward for nomination to the Council. The Staff Council has representatives on the Board of Directors and the ability to influence Board decisions. The Council represents the views, opinions and interests of staff on the Board. In the quote below, one Social Enterprise nurse manager describes how organizational mechanisms such as Staff Councils give front-line staff the opportunity to exercise some measure of influence over strategic decisions.

Interviewee. The other thing about social enterprises is, because you [an employee] can be a shareholder within it, we have things like shareholder meetings. We have the ability to be able to vote on things, and we have a Board which is driven by those shareholders, so, there is a kind of model where it is like a shareholders' group that very much influences what is happening on the Board level. And the chair of this shareholders' group sits on the Board.

Interviewer. I see. So, there is, in addition to the Board of Directors, there is a separate governing body, that of shareholders, and everybody can be a part of that.

Interviewee. You can be, yeah, you can be nominated to go and sit on that as part of your locality or whatever.

Interviewer. That is represented on the Board of Directors?

Interviewee. Yeah. So the chair of this sort of shareholder Board sits on the Board, proper Board. So, they are a NED effectively, a non-executive Director. So, again, that is influencing, kind of, it almost feels a little bit like there is an ability for the viewpoint of the man on the ground to potentially get to Board level, you know. And I think that sometimes within other organiza...public sector organizations, in particular, because they are massive and unwieldy, the Board is miles away from the staff on the ground.

So, I think that ability to be able to influence that...[as] shareholders we got to vote on decisions around...they called it Total Reward. So they put in to change our pay

and conditions in order to enable us to offer the NHS pension to staff who came in who weren't on the protected NHS pension. And so we were able to vote on that as shareholders as to whether or not we were happy with that proposal, and there was a number of proposals that we could offer. Some were diktats that we have to do, but some were, we could vote on this as an idea of option A, B, C, what people think. So, again you got an ability to be able to influence on decisions that are being made at a high level, financially, you know, in terms of being part of that decision-making process, which, I think, is a really, really good thing.

It stands to reason that if social enterprises take the idea of employee involvement in strategic decision-making seriously, they would have involved staff in the first and most fundamental decision: to leave the NHS and become a social enterprise or to stay within the NHS (Hall et al., 2012). One interviewee made an interesting comment in this respect: 'There was a lot of involvement of staff in the kind of reasons why we were thinking of becoming a social enterprise. At that point I was a clinician, not a manager, so, I wasn't involved in any of the kind of decision-making around...I just went to lots of consultation meetings where they talked about what the advantages were, potentially.' This comment is interesting because it suggests that while frontline, and particularly, clinical staff were informed, they may not have had an effective say in the decision. Low (2011) found a similar chain of events at another Social Enterprise. Examining the preliminary discussions at another social enterprise before it spun out, he discovered that although the majority of staff opposed the decision to spin out, the top management went ahead anyway. This raised doubts about whether Social Enterprises were sincere about involving employees in strategic decision-making, and whether bodies such as Staff Councils were truly able to represent staff views and interests at the senior management level. This concern was refuted by another interviewee who maintained that social enterprises were making a genuine attempt to give real powers to bodies representing employee interests and, through them, to give staff on the ground a meaningful say in important organizational decisions.

Interviewer. You are familiar with consultations within the NHS which can sometimes be tokenistic, so, it is a question of whether these attempts to involve employees are meaningful, whether they have teeth, or whether they are just

tokenistic exercises. The one pound equal membership for everybody in the organization, again, is that just a gesture or does it go deeper?

Interviewee. Yes, it goes deeper. They, have rights within our articles of association that ultimately mean they can remove our Board of Directors. The Members' Council appoint our non-executive Directors. They have just been through that process for the second time of appointing our non-exec Directors.

Interviewer. And the non-executive Directors are represented on the main Board of Directors.

Interviewee. Well, our main board is eight people. Four of them are non-executives. Four of them are executives, so, half of the board is made up of people who the Members' Council have interviewed and appointed.

Interviewer. Right. Good.

Interviewee. So, they have very much had a say on that. The non-executive Directors are responsible for the pay and remuneration of the executive Directors, [and] the Members' Council are responsible for the appointment and remuneration of the chair and non-execs.

A nurse manager at a social enterprise gave a concrete example of how the Staff Council that represented the views of frontline employees on the Board was able to influence a major decision on payment of travel allowances to employees. The Staff Council mechanism enabled frontline staff to have their say over a strategic organizational decision that affected them vitally.

There was voting for and against but there was also an opportunity to feed into the decision-making process. For example, there was one which was you lose the standardised mileage payment for your car, and you just get paid for the number of miles you do. And what will happen is, if you do loads and loads of miles, you, then, start getting taxed on them. One of the things that was raised as part of this kind of voting process was that there were some people who would be

disadvantaged because they would earn too much mileage and they get taxed on it. So then they worked out who would be at disadvantage and, then, created payments to those staff to make up for that disadvantage. And that came out of this kind of consultation-voting process around, actually, we are not happy with that part of it. Because the Staff Council have such influence over the decisions that are being made, and everything has to kind of go through them, actually, they were influencing as well. So, things were evolving whilst we were voting, yes, we are pretty happy with Total Reward.

An employee from another social enterprise also echoed the more collaborative and collective decision-making style gaining ground in social enterprises. In this organization, employees are involved in shaping policy decisions: '[Decision-making] seems to happen more quickly. And more people are involved in it as well. All staff, not just a manager, will develop a policy. Team Leaders will, some staff nurses will, so, everyone is aware of what that process is, rather than it being something that somebody else does much higher up.' One social enterprise employee spoke of how the rank and file were consulted in an important organizational decision – the naming of the new fledgling enterprise: 'Actually, front line staff do have a say in important organizational decisions because staff members chose the name of the organization. Clinical staff decided that we are going to be called [name of social enterprise].'

A sub-theme that emerged in the course of the analysis is that employee involvement in strategic decision-making in social enterprises was a work in progress. Though social enterprises had made significant advances in this direction, much remained to be done to fully realise the mutuality dimension of social enterprises. As one interviewee said, 'I don't think we have really nailed exactly how we do some of that very effectively.'

The geographically dispersed nature of the community work that many social enterprises do added to the challenge of employee participation. It was difficult to bring all staff together at the same time to participate in a collective decision-making process. As this interviewee said, 'I think, if we were a hospital, we could make that happen as a social enterprise more easily. When you are twelve hundred people doing a million and a half miles a year, travelling round

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[geographical places] and, shortly to be, [geographical place], it just becomes more difficult to pin down really.' Some social enterprises were responding to this challenge by using technology to bridge distances and enabling staff to participate from a distance in important organizational decisions.

Some Social Enterprise staff also spoke of the risk of burdening clinical staff already under a lot of pressure with yet more responsibilities. One Operations Manager described how the ideal of involving frontline employees in strategic decision-making was tempered by the reality of increasing workloads and disinterest from clinical staff who do not see the relevance to their clinical roles or are simply not knowledgeable, interested or motivated to take part in shaping organizational strategy: 'Clinical staff are given the opportunity to be involved in important decisions about the organization. Lots of information is circulated on their intranet to keep [them] posted but clinical staff, owing to their busy schedules, and because they are so far removed from the chief exec level, are often unable to free themselves enough to take part.'

Another interviewee described how there was a downside to employee involvement and that there were potential tensions and trade-offs between employee involvement and organizational agility and speed in decision-making.

> The danger is, it means that the board becomes ineffective or impotent, and, then, you lose all the benefit of being fleet of foot with some of this. I mean, it is one of the largest social enterprises in the country. If you have got a roomful of people, and that roomful of people are it, and you are running a little social enterprise, you can involve everybody in it, and you can say, 'What about such and such'. When you are trying to deal with a social enterprise that has got twelve hundred people, we aspire to doing what you have described but I don't think we have yet cracked exactly how to do that. But we have plans in April to get some of our Members' Council people looking at some of these issues along, particularly around what the benefits of being shareholder are. We need to work through that in a more fundamental way because we have got some of the answers to what the benefits of

being a shareholder are but they are not very strong. There is much more that needs
to be put into that side of it.

6.2.9. Innovation

In this section, the changes in the innovativeness of Social Enterprises and the impacts on the equity-supportiveness of their organizational cultures are analysed.

A benefit of the social enterprise model that came out during the analysis was that social enterprises were encouraging innovation to a greater degree than NHS organizations (Chew and Lyon, 2012). Less bureaucracy, faster decision-making processes, a leadership that is more willing to support risk-taking and experimentation had resulted in an organizational climate that was hospitable to new ideas. Innovation can support equity as new technologies, new techniques, etc. can be developed to provide services to groups who were hitherto unable to access services, or to meet their needs better; service pathways can be re-configured to remove the barriers that prevent certain populations from obtaining access to services. Thus, the greater innovativeness of social enterprises is likely to support a more equity-oriented culture.

One interviewee described how they had introduced a new scheme that offered paid internships to graduates from local universities who might otherwise have struggled to obtain jobs. Offering these struggling graduates job opportunities within the organization enabled the social enterprise to promote social justice and equity. The graduates were able to gain valuable work experience which, then, served as a stepping stone to further development of their careers. This quote illustrates how social enterprises invest their surpluses in the local economy, thereby, generating growth and revitalising local communities. One of the advantages of social enterprises is the added social value that they bring, and this is an example of that. This initiative was a win-win for both parties as the organization got young blood and new ideas. This influx of fresh graduates had the potential to boost innovation within the organization as the graduates brought with them the latest skills and know-how and different perspectives.

Thus, offering these job opportunities to graduates was an innovation by the social enterprise that created a supportive climate for further innovation.

Interviewee. We came up with the idea, when the recession was at its height, and graduates were finding it particularly hard to find jobs, at the time when internships were very much unpaid internships even in Tesco and places like that, that we would create opportunities for graduates, recent graduates, to get 9 months of paid work experience in all sorts of different places. So, we said, well, we don't know, sounds OK, sounds like there might be some advantages for both the graduate in getting some work experience and for us in getting some fresh ideas. Three years later, we have had thirty two graduates come, and some of them have stayed on in permanent jobs. Some of them have gone on to higher education again, and the remainder have got great jobs that they wanted out of it, jobs that they wouldn't have got if they hadn't had the experience at [name of social enterprise]. It gave them that opportunity. We tried it small to begin with, with two people, and it has given us, as I say, thirty two people who were struggling to find an opportunity, an opportunity.

In discussing the culture of supporting innovation, some social enterprise employees contrasted their present empowering culture with the culture of conservatism and risk-aversion within the NHS. They remembered with regret how attempts to introduce change were discouraged and new ideas languished for want of support.

There isn't a culture here of just standing still, and there isn't a culture of being afraid of change, and is not risk-averse...[we] won't take massively scary risks but it is not completely risk-averse. So there is a culture, for the two managers that I have had, of supporting, you know, reviewing, and listening to what you think, and taking risks, and I think that is great. And I didn't experience that in the NHS. I don't think I have ever experienced that in the NHS...change was just really, really difficult. And any good managers were stepped on, and pushed aside. Isn't that awful? It is true.

Among the factors that enabled social enterprises to promote innovation, a leaner, flatter organizational structure was cited as one of the key contributory factors: 'I think that we are a relatively flat organization in terms of structure, so, ideas can come up through the organization.' Another important factor that supported social enterprises in being more innovative was having greater control over their finances and being able to re-invest surpluses strategically.

Innovations that this organization has been able to do is the implementation of mobile working for staff, so, they have invested. They made a decision that because it is community-based, that people were wasting a lot of time travelling to and from desktop spaces, so, give everyone a tablet, give them access to be able to input their progress notes, information about patient care on to that and, then, have that upload up on to the system... [This] will save time, so, it is worth the investment. It is like spend to save, I suppose, kind of approach. Because we have complete autonomy over what we do with the finances of the organization, it means that we can do that without anybody kind of going 'Why are you doing that? What is that all about?', or, you know, clunky processes. So, I think it has allowed innovation that, perhaps, I haven't seen before in organizations, so, that is one part of it. So, the ability to reinvest in your own service, so if you can make a profit, you can invest. In other public sector organizations, you know, you generated income and no one ever saw it again. It disappeared into the ether, was never seen again... Because we kind of own the company, we have the ability to be able to reinvest in the company, and that gives you opportunities to, perhaps, try things out that you might not be able to do within the kind of constrained typical public sector model.

Social enterprises differ from public sector organizations and the third sector in cultivating financial self-sufficiency and being less dependent on grants from governments or private donors. Instead, they develop independent revenue streams by trading and offering their services to generate incomes (HM Treasury and Cabinet Office, 2007). One interviewee described how being a business and the need for social enterprises to be financially self-reliant

acted as a spur and stimulant to innovation. This quote also reinforces the point made earlier that the greater autonomy and flexibility granted to staff in social enterprises has encouraged innovation.

> I think we have been able to do things that, maybe, we wouldn't have done in the past. So, you kind of can offer your services for things, is how I describe it. So, within my service, the sort of freedom that I have been able to do is to go to other organizations and say, 'Look, we have got these really specialist staff, and what we could deliver for you is some education and training in primary care to upskill your nurses so that they know what to do with these types of patients. What do you think about that? And they go, 'Brilliant. That sounds great. How can we do that? And, then, they pay us to do that. So, that kind of freedom to be able to be innovative and do something a bit different is encouraged...When I worked in the NHS, it wasn't quite so, things felt much clunkier, is how I would describe it. It felt like everyone was very risk-averse to doing any of that kind of stuff.

Though the pressure to generate revenue by selling services can be a stimulus to innovation, there is a potential negative side. Pressure to generate business and income carries the risk that clinical staff and managers will get distracted from their main role of caring for people. The literature cites several instances of social enterprises getting transformed over time into entities indistinguishable from purely for-profit private organizations due to commercial pressures. 'Mission creep', as this phenomenon is called, is rather common in the history of social enterprise.

6.2.10. Use of Technology

In this section, the changes in the use of technology in Social Enterprises and the impacts on the equity-supportiveness of their organizational cultures are explored.

Technology, especially the use of digital technology, emerged as a critical differentiator between Social Enterprises and NHS organizations. Given the financial pressures on public health services, digital technologies have attracted significant interest due to the potential for substantial cost and time savings, and e-health is a burgeoning area of research. Social Enterprises, it appears, are making more effective use of digital technology in a wide range of ways, thereby, achieving productivity and efficiency gains, improving communication, and spurring innovation. As one interviewee said, '[Social Enterprises are] re-investing money into new and better ways of working...Things are more streamlined. The digital technology frees up time and resources and using virtual appointments; all of those things mean that staff and resources are better used... So, that definitely happens, and another reason why I came to work for a Social Enterprise.'

Social Enterprise interviewees expressed regret about the relative technological backwardness of IT systems within the NHS. They contrasted this with the freedom and the resources they had as a Social Enterprise to adopt newer, more advanced technologies that were better suited to their needs. In the extract below, one interviewee describes how their Social Enterprise is harnessing the power of e-consultations. Virtual consultations have the potential to improve equity as patients don't have to physically come into the clinic to be seen. In addition to benefiting ordinary patients, this could particularly benefit the poor who have difficulties in accessing services due to the expenses of transport or taking time off work, and those who have problems with mobility as in the case of the very elderly or the disabled.

> Along with that, we've gone digital, so, that's a huge change. And I don't think we would have done that necessarily if we'd still been part of the NHS because we've obviously got more flexibility now. And we're certainly streets ahead of many organizations who are nowhere near our level of technology. We do LINK calls, we do some virtual patient consultations now across the organization where it is appropriate and where it is actually clinically safe.

> How we've changed is the sort of way we can deliver treatments. If I give you an example of Podiatry, which is one of the services I manage. They can do e-

consultations which means, instead of a patient having to come in, if, for example, they have got a really painful toenail, we can actually see them over a [computer] screen...It [the transmitted picture on the computer] is very clear, so, the Podiatrist could say, 'Right, you don't need to come in, or yes, I am going to list you for theatre. And they could do the consultation over an electronic system. Saves time. It saves the patient having to come in. They obviously have to come in for the actual treatment but it cuts out another appointment.'

From a dental perspective, another service that I manage, we've just developed a video for the service. Dental, you get a lot of patients who are phobic about coming in. So, they can see the video. They will know [what is likely to happen in the dental appointment]. So, they might feel less likely to DNA, you know, not attend their appointment.

With dental, we are also hoping to go digital, from an X-ray perspective, which, obviously, will require quite a large, significant investment in the service but the benefits will be great because we are trying to get paper-lite, paper-less. And we can only do that by investment because X-rays currently aren't digital. They are paper, you know, a copy of an X-ray whereas we want to have them all on a system so [that] we are reducing the amount of files and all that stuff we have around...We want them all on one device.

Dermatology, they are also doing e-consultations. The specialist nurses started to do those, so, she might treat them, and they might then show her what the rash is like. They can decide whether that person needs to come back in, or whatever.

I know that although I don't manage District Nurses, I know if a District Nurse or an Assistant is out in the community and they are concerned about something - it could be a sore or a wound or something like that - they can actually say, 'Right, X [their colleague based in the social enterprise], sitting at your desk in, wherever,

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'Can you have a look at this wound and tell me what you think?' And that means that nurse doesn't have to go out but they can advise someone there and then. So, it does work, and, actually, we've stopped a lot of travelling because we've a lot of our meetings via LINK. So, I might be sitting 20 miles away but I can still join a Podiatry staff meeting here, and I don't have to travel, so, it does work really well.

A senior manager described the benefits of technology for providing more personalised, patient-centred, equitable care. Describing the drivers for the increased use of technology by their Social Enterprise, he said that, of course, the need for efficiencies and the potential for digital technologies to provide care at less cost was an important consideration. However, another important driver of the use of technology, he said, was making services relevant to future needs. Given the likelihood that there would be fewer resources in the future to deal with the needs of older people, say, technology, he suggested, was one of the key ways of tailoring care to meet the future needs of people. The extract below cites two examples he gave of how their staff were using technology to better meet the needs of patients, especially, those with unconventional or additional needs.

Member of staff went into an elderly chap's home who had multiple needs, multiple long term conditions, beginning to suffer with dementia. He was agitated and he wasn't agitated because of his conditions per se. He was agitated because he knew that he had got lots of other people – health, social care – coming into his house, into his life, and he didn't know when things were happening. So, the nurse was able to open up the laptop and say, 'Right Mr. So and so, I am looking across all of your care record here. I can see when the other appointments are. Let me write them down for you. So, there you are. You can see. You can be less agitated now because you can see what to expect and when to expect it.' So, it is not just about the face-to-face consultations, it is about the other things it can bring because you have got that record all in one place. And that is a real example.

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There is another brilliant example of an elderly lady who kept taking off the bandage which meant that [her] leg ulcer kept getting worse. And in the course of the conversation, the lady was talking about the things that she liked, and she said that she liked Mario Lanza music. And the nurse was able to say, 'Mario Lanza, right. Tee tee tee tee tee'. Put some Mario Lanza music on. And the nurse bribed her basically and said, 'If you like that, if you leave your bandage on, next time I will put some more Mario Lanza music on. How about that? And it worked. So, it is using it [technology] to its fullest opportunity, using it to meet the need of that patient, in the way they need it, not necessarily in a prescribed way of consultation or whatever.

Being a Social Enterprise was described by several interviewees as being an important pre-condition for the use of the newer, more advanced technologies. Having greater control over internal organizational decisions, having the ability to make changes, to manage their finances and choose how resources were to be used were stated as important contributory factors to the technological advances made by Social Enterprises.

Interviewee: Obviously, there needs to be investment in technology, doesn't there? It is whether we would have been able to afford to do it if we weren't a social enterprise. I think we probably would have moved forward with some things if we hadn't been a social enterprise but I am not sure whether we would have got as far as we have without [becoming a social enterprise]. I don't know whether [we would have had] the investment, the finances to do that. Obviously, being able to be more flexible, because we manage our own finances, don't we, [has made these changes possible].

Interviewer: So, would these changes not have happened if you were in the NHS?

Interviewee: I think it would have been more difficult because there just isn't the funding there, is there, to make changes? You carry on doing the same thing really.

6.2.11. Service User Involvement and Co-production

In this section, the changes in service user involvement and co-production in Social Enterprises and the impacts on the equity-supportiveness of their organizational cultures are explored.

In Social Enterprises, the idea of collective participation in important decisions about the organization goes beyond involving staff and extends to patients and service users, too. An important feature of social enterprises is the idea of 'Co-production', or the design of services in active collaboration and partnership with service users (Pestoff, 2009; Brandsen and Pestoff, 2006). Healthcare organizations have traditionally conceptualised patients and service users as passive recipients of care. Social enterprises, in contrast, assign greater agency to the recipients of care and view them as equal partners and co-creators in the process of constructing appropriate solutions to their care needs. Instead of having solutions dictated to them, the receiver of care is expected to take ownership and responsibility for their healthcare needs and play an active part in the design of the solution. One Social Enterprise interviewee described well the difference in approaching service design in a spirit of co-production: 'Sometimes I get frustrated with people saying about having consultations, or we will put a questionnaire together and we will ask people what they think. You have already put the questionnaire together. You have already influenced what the answers are gonna be. Why do that? Why not work with them, and then you will know.'

Co-production has clear implications for promoting equity in service provision as no clinician knows, or can know, the needs of patients better than the patients themselves. So consulting patients and involving them in a meaningful way in the design of the service is one of the most effective ways to promote equity in care provision. One of the strengths of social enterprises, historically, has been that they actively seek the views of service users and patients and involve them quite actively, and to a much greater extent, in service design. One social enterprise employee described how they were involving their local community actively and 'co-creating' services in partnership with service users.

It is more about a model of giving up an 'us' and 'them' mentality, and using an 'us' mentality, which is quite scary for clinicians. It was certainly quite scary for me. [Another member of staff] did that first for Falls. And when she said that she was going to teach members of the public to do walking aid assessments – it is not about assessing for the walking aid – it is to see if they are safe. And there are some very simple things you can do to see if they are good or not, simple things. Then, they are not going to do anything else. All they are gonna do is identify.

And the other thing that she said to me quite clearly at first is, 'One person talks to another person, and they give them advice that they think is right. Why don't we tell the people what the right advice is to tell other people and let the right messages spread out there through social networks?' And that's the way we do it here. So, it is not about taking the power, taking the clinical specialisms away from people. It is just allowing those messages, those correct messages to filter through and back again. That is another thing we do here that other people don't necessarily do.

Yes, we have got the volunteers. We have got about a hundred volunteers. They play a great part in what we do. They go out into the public and give them good advice but because we are all together that links back in, so, if they find somebody and answer their questions, they can tell them to go to the GP, and then get them back in here, or sometimes they will just come straight back for Falls self-referral, but because they can also keep coming back to us, and asking us the clinical things, 'This is what they said and this is what I said, what do you think?' Now, we don't say, 'This is what you should say to everybody but we can educate them a little bit more so that they can signpost, and that is really one of the things we think our volunteers' major role is, they signpost into good practice. And that might be here at Hope Street or it might be things like carers' associations or, as we go around you will see how many strands we interact within our local community because that is the other thing.

We do quite a lot of work with the kids with Falls as well. We had Falls packs because some of our volunteers are teachers, and they worked with, actually, some of the younger people who were causing trouble, to create packs that we delivered to kids, about 8-year-old kids. What they did is, they became Fall Investigators. So

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there is things in there where they look for, identify the Falls risks, what could cause a fall, and then they went to an older person – their grandparents or someone else - with somebody, and they went around and spotted the risks. So they are educating the older person about Falls but they know about it as well.

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Chapter 7: Conclusions of this Research Project and Recommendations for Future Research

Overview of the Chapter

This chapter is divided into five sections. In the first, second and third sections of this chapter, the findings from the quantitative and the qualitative strands of this research project are synthesized and the contribution to knowledge of this research project is articulated. In the fourth section, the findings of this research project are placed in the context of the wider literature on the subject. The policy implications of the research findings are drawn out and suggestions are made for healthcare professionals and policy-makers to consider. In the fifth and final section, the strengths and limitations of this research project are analysed and

suggestions are made for future research that could build on this project and extend its reach and impact.

7.1 Contribution to Knowledge of this Research Project

This research project began with the question: do the organizational cultures of NHS organizations and Social Enterprises differ in their equity-supportiveness? The results from the quantitative strand indicate that, at present, the answer is no. Though Social Enterprises (SE) did report higher mean supportiveness for equity, the differences between SE and NHS organizational cultures are not statistically significant. However, the fact that Social Enterprises reported higher mean supportiveness for equity suggests the cautious assertion that, so far, equity in service provision has not been harmed by the externalisation of parts of the NHS as Social Enterprises, and more importantly, that the changes brought about by Social Enterprises since their spinning out has the potential to improve equity in care. These potentially beneficial changes are described in more detail later in this chapter under the summary of the qualitative findings from this research project.

The findings from the quantitative strand also indicated that there were no statistically significant differences between NHS organisations and Social Enterprises in respect of the equity-supportiveness of their organisational missions and values, in the importance staff gave to equity in service provision, and in terms of the presence of equity-promoting organisational mechanisms. The equity-supportiveness of the organization's mission and values were recognised as the most significant influences on the importance staff accorded to equity in service provision, with organizational mission being the most important determinant of staff's attitudes to equity.

The quantitative analysis also suggested that the clear assignment of responsibility and accountability for equity in an organization (for example, through the appointment of a dedicated Equalities Lead or the explicit assignment of this task to a named individual who shared this role with other duties, such as a Quality Lead or a HR Manager) and the inclusion

of equity issues in routine performance management processes (for example, through demonstration of the promotion of equity being made a part of clinicians' annual performance appraisals; through rewards and promotions being linked to the promotion of equity) were key drivers of equity and held the potential to spur individual and organizational efforts to promote equity.

The results from the qualitative strand correspond to the findings from the quantitative strand in respect of the potential that the organizational changes made by Social Enterprises have for improving the equity of care. The qualitative analysis suggests that there are some valuable lessons for NHS providers in the organizational changes that Social Enterprises have made. These changes and the recommendations for NHS providers are summarised below.

It is worth observing at this juncture that quality of care has implications for the equity of care. Poor quality of care for all patients will tend to disproportionately disadvantage and hit hardest those who are the most vulnerable and least able to complain such as the elderly or those from ethnic minority communities (many of those worst affected by poor care at Mid-Staffs were the elderly and the infirm, and the Francis Report (Francis, 2013) dedicated a separate chapter to ensuring proper care for the elderly). Thus, poor quality of care exacerbates existing inequities. Conversely, as a rising tide lifts all boats, an overall improvement in the quality of care will tend to improve the quality of care for the most marginalised groups, too (thereby, improving equity). While the focus of this research project is on equity of care, it is acknowledged that equity is inextricable from (though not equivalent to) quality of care. Therefore, the findings and recommendations of the Francis Report (which centred on ways of improving the quality of care) are woven into conclusions about ways of improving the equity of care. Also, because of the comprehensive scope of the Francis Report, its particular focus on organizational culture in NHS organizations (thereby, resulting in significant areas of overlap with this research project), and its profound influence in shaping the post-Mid-Staffs public healthcare landscape, the report is used as a framing device to contextualise the conclusions of this research project.

SEs have made many changes which have the potential to increase organizational efficiency, improve the working conditions for employees, and enhance the quality and equity of provision for patients. These changes hold important lessons for NHS providers. In the paragraphs below, these changes are summarised. Based on these changes, recommendations are made for NHS providers to consider.

SEs have made their organizational mission and values much more transparent and visible to staff. As a result, they have been able to achieve better alignment between mission, values and day-to-day operational practice. The gap between rhetoric and actual practice has been narrowed. SEs have communicated their values to staff through socialization sessions and embedded them in their HR practices such as recruitment. The values actually inform the way the organization works. This has improved the quality of care for patients and the morale of staff. SE staff showed greater awareness of the organizational values and felt that they were relevant to their day-to-day work (such as recruitment and induction for new employees). Staff perceived the sincerity and integrity of senior management in practising the organizational mission and values, and this motivated them to live by those values themselves.

The NHS, too, has been taking steps in this direction through the mandatory requirement of EDS 2 and the implementation of the Compassion in Practice strategy. However, more needs to be done in the NHS to close the gap between espoused and lived values. The Francis Report found a surprising and regrettable lack of awareness of the NHS Constitution and NHS values among NHS staff in the Mid-Staffs hospital (and other NHS organizations that took part in the inquiry), leading to their under-utilisation by staff and patients in upholding standards of care (Francis, 2013).

Leadership in SEs is much more visible and accessible to front-line staff. New technologies have been utilised in SEs in the service of achieving a better flow of communication between the leadership and the front-line. The closeness and availability of the top leadership offers real and tangible benefits to the frontline healthcare professionals who actually deliver the services. Frontline staff are able to obtain speedier, more decisive responses to their ideas which enables them to adapt services to the requirements of their patients quickly, thus increasing patient satisfaction. Senior management also benefit as they receive more accurate, less filtered, less distorted information and become aware of problems and challenges sooner. They are, therefore, able to obtain a better appreciation of the changing needs of patients and are alerted sooner to incipient problems in the organization. The result is a more agile and nimble organization, one that is able to move rapidly and keep pace with changes in the external environment, and an organization that is more responsive to the needs of patients as well as of the frontline healthcare staff who serve the patients.

There has been considerable devolution of responsibility and authority to clinical staff in SEs, and this has assisted in improving the quality and equity of care. Greater autonomy and decision-making power for clinical staff has enabled them to put into practice ideas for making improvements in services. Staff had these ideas even when they were in the NHS but these ideas languished for want of encouragement or sometimes even active discouragement. The bureaucratic regulations and extremely slow pace of change in the NHS stifled some of these ideas and prevented them from reaching fruition. The Francis Report was critical in its assessment of the bureaucratic organizational mindset which hinders NHS staff from offering the best possible care: 'Structure drives culture. It is not possible to create a world-class service culture as long as we keep structures that are defined by layers of bureaucracy and departmental barriers to speed and responsiveness. The most important single change that can accompany a strong service message is spontaneity, the power of inspired front line staff to say Yes and do the fair or generous thing on the spot' (Francis, 2013; p. 1550).

Bureaucracy can stem from many causes. Reluctance to change is one of them. The Francis Report indicated that resistance to change by clinicians was one of the contributory factors to the abuses that took place at the Mid-Staffs hospital. The report cited Dr. Dr Philip Coates, a Diabetes Consultant and clinical lead at the Trust for clinical governance, as suggesting that

consultants at the hospital were not keen on change: 'It may be the case that Stafford was particularly recalcitrant in terms of picking up the newer ideas and going with clinical governance agenda... in some ways some consultants here have been relatively old-fashioned in their approach' (Francis, 2013; p. 173).

Due to their operational independence from the NHS, SEs have been able to simplify processes and eliminate or reduce many of these bureaucratic hurdles and thereby enabled staff to execute their ideas for service improvements. This has not only helped to raise the standard of care, it has also improved employee morale and given SEs a competitive advantage when bidding for contracts. Moreover, acting equitably becomes much more difficult when staff are constrained by bureaucratic regulations.

One of the primary features of a SE model is a more democratic and egalitarian ownership and decision-making structure where the rank and file have a broadly equal voice in important matters pertaining to the strategic direction of the organization. Greater representation in steering the organisation and making important organisational decisions has the potential to improve employee engagement and staff morale. Many staff in NHS organizations feel disconnected from important organisational decisions and the leadership should consider giving their employees more influence in determining the strategic direction of the organization. The Francis Report highlighted a lot of disillusionment, cynicism, and even despair among clinical staff, even some very senior clinical staff, in influencing the course set by management, for example, in relation to staffing issues or disciplining of offenders. Many senior clinical staff felt that their concerns went unheard and unheeded by the management (Francis, 2013).

The contrasting democratic and inclusive style of decision-making adopted by SEs has important lessons to offer NHS Trusts. At the same time, it should be recognised that many SEs still haven't fully realised this John Lewis-type egalitarian partnership model and that although they are further along the journey than most NHS Trusts, for many SEs it is still an aspiration that they are working towards. It is a work in progress for many SEs, too.

SE staff feel that their workplace climate is much more hospitable for experimentation, risk-taking and innovation. An entrepreneurial mindset is encouraged in SEs. SE staff suggested that the culture in NHS Trusts is highly risk-averse. SEs have succeeded to a greater extent in striking a fine balance between taking risks to pursue new opportunities and avoiding undue risks. This has allowed them to develop new services to meet unfulfilled needs of the communities they serve. It has also allowed them to generate new revenue streams, diversify their businesses, and become more financially independent and stable.

Financial autonomy has made it possible for SEs to support their staff in innovating. Since SEs retain their surpluses and have the freedom to invest it according to their needs, they are able to fund promising new ideas and projects and reward staff for meeting performance targets in challenging times. They can reinvest a portion of their surpluses in upgrading their equipment and facilities, thus, raising the standard of care they offer. They are also contributing to the re-generation of the local economy by investing in the local talent pool, by purchasing services from other local Social Enterprises, and by supporting worthwhile local charitable projects. This has assisted SEs in increasing their social impact and given meaning to the *social* in *Social Enterprise*.

SEs are engaging with and involving their patients much better. As a result, they are achieving better outcomes for their patients. SEs are harnessing the potential of co-production of services a lot more fruitfully than many NHS Trusts. Some SEs have won national recognition for their pioneering efforts in this respect. For NHS Trusts to achieve the same kind of patient involvement and engagement requires a fundamental change in the attitudes of healthcare professionals and the way they perceive the clinician-patient relationship. Clinicians in the NHS need to get better at educating patients and offering them more opportunities for decisions about their care. This requires a shift in the balance of power between clinicians and patients and a more democratic, equal and participatory relationship. It might be challenging for some clinicians to cede power and authority but is necessary to move towards a more patient-centric model in the NHS.

NHS organizations could usefully learn from SEs how to make more effective use of technology. By making better use of existing technology and by investing in new, more advanced technology, SE staff have improved the quality of care while reducing costs. This has given them a distinct competitive edge over the NHS. Given the tight squeeze on resources, it is imperative that the NHS makes the best possible use of technology to get the most productivity out of its staff.

SEs are making better use of technology to improve the flow of communication, support their highly mobile staff (especially those who work out in the communities), reduce costs and improve patient care. SEs are able to do this partly due to their operational freedom. Not being tied to NHS procurement policies gives SEs the flexibility to choose the IT systems that best meet their requirements. Financial autonomy enables them to invest surpluses in new technologies which increase the productivity of staff and the quality of care.

In the private sector, the best-run large organizations are able to allow their different units the room to customise their IT systems to best meet their individual requirements while ensuring that there is compatibility and harmony in operating standards between the different parts of a company. It may be possible to find a better balance in the NHS between the need, on the one hand, to allow different Trusts and departments to choose the IT systems that best meet their needs and, on the other hand, to ensure uniformity and standardisation so that the different IT systems are able to communicate with each other seamlessly.

In particular, the NHS could take a leaf from SEs in how to deploy e-technology better. The field of digital technologies has witnessed rapid advances in the last decade, and the growing research in this area hints at its potential to lead to more innovative, cost-effective, accessible and equitable care. However, digital technology is still relatively under-utilised in the NHS. SEs could suggest ways in which the NHS can harness the potential of e-technology to improve patient care and equity in service provision.

The use of technology by SEs to improve the flow of communication both vertically and horizontally within the organization offers some salutary lessons to the NHS. One of the reasons why the sordid state of affairs at the Mid-Staffs hospital went unchecked for so long was the failure of systems of communication (Francis, 2013). Important information relating to concerns about the quality of care at the Trust was not shared between organizations that could have intervened to stop the abuses. By making better use of technology, SEs are streamlining the flow of communication so that intelligence is shared more rapidly and so that decision-makers have more of the necessary information to make good decisions. Greater accessibility and better sharing of information has also increased the effectiveness and productivity of staff.

7.3 Disadvantages of the Social Enterprise (SE) Model and Cautions against their Premature Widespread Use

The Francis Report which investigated the abuses at the Mid-Staffs NHS Trust attributed the failure of the duty of care to patients primarily to a blinkered focus on meeting national targets and prioritisation of the Trust's business objectives and financial performance over the safety and wellbeing of patients. Patient safety and quality of care were sacrificed at the altar of balancing the books and achieving Foundation Trust status (Francis, 2013). The report stated that the senior management of the organization 'took their success at balancing the books as being the benchmark to which to aspire and paid insufficient attention to the risks in relation to the quality of service delivery this entailed' (Francis, 2013; p. 172). The Francis Report was unequivocal in recommending that putting patients first in all the work done by the NHS be made the *overriding* principle of the NHS (Francis, 2013; p. 1436).

In for-profit businesses, there is an uneasy tension when deciding whether to put the business imperative for profitability or customers (patients) first. As is clear from the example of Mid-Staffs, NHS Trusts, too, struggle with this dilemma. However, SEs may find this especially challenging as they are much more self-consciously independent *businesses* and lack the political and financial resources of the NHS (Francis, 2013). If SEs aspire to profit-maximisation as a business, and do not address the tensions this might pose to quality and equity of care, they might be susceptible to the same corrosion of the organization's quality

and care culture as took place at the Mid-Staffordshire NHS Trust and, in a different but analogous context, in private sector organizations such as Enron and Arthur Andersen which were mired in corporate accounting scandals of a breathtaking scale because of unresolved tensions between conflicting organizational missions. Clearly, as the example of Mid-Staffs shows, this can happen at NHS Trusts, too. However, SEs' independence and consequent lack of a safety net makes them, perhaps, more vulnerable to financial pressures.

The Francis Report highlighted the need for proper *accountability*, especially in respect of senior leaders and managers, and the imposition of sanctions on them should they not meet the desired standards of performance or fail to adhere to the expected codes of ethical and professional conduct. The lack of a designated Equalities Lead in many SEs makes proper accountability more challenging. While the Equalities Lead function is relatively clear and well-resourced in NHS Trusts, it is much less so in SEs.

This is a concern that needs to be addressed, as the absence of clear accountability for promoting ethical and equitable behaviour is associated with a higher probability of ethical mishaps. There is a clear need in SEs to communicate clearly and unequivocally to all staff which individual has ultimate responsibility and accountability for promoting equity in the organization. In the turbulent and challenging healthcare environment, amidst all the pressures, SEs could lose focus on the important goal of promoting equity unless they consciously prioritise it by assigning this task clearly to someone. The diffusion of responsibility for equity in the absence of a named individual, as tends to be common in SEs, can create a situation where equity is de-prioritised and inequitable care can result.

The Francis Report emphasized the need to hold care-givers, both individuals and organisations, sufficiently accountable for their actions (Francis, 2013). Private ownership, as in the case of SEs, entails private accountability. SEs are not accountable to the public in the same way that NHS Trusts are. This dilution in public accountability can be reasonably expected to have ramifications for equity. Kirkwood and Pollock (2016) contend that private providers (SEs are, strictly speaking, private organizations as they are privately owned), even where they provide public services, are exempt from the Freedom of Information Act 2000.

Further, they argue that the cloak of secrecy around private providers has hindered comparisons of standards of care across private and NHS providers, and that, as a result, poor care by private providers has gone undetected.

A problem with the SE model is the lack of clarity around the *precise* definition of the SE model – what it is, what its constituent features are. There is a lack of understanding and unanimity, or even a consensus, among NHS providers, commissioners and policy makers about *exactly* what being a SE means. There is no universal agreement, even among SE staff, and no consistency, about what it means. The term *SE* seems to be very flexible and to lack precise limits or boundaries. The problem is that Social Enterprise is not some specific, highly defined concept (in contrast, another example of market-driven reform, the Private Finance Initiative, was more specific and well-defined). The SE model does not correspond to any clear and agreed set of values, standards of care, or specific management and operational practices. There is clearly a need for a tighter operational definition of the concept.

In the absence of clarity and agreement on exactly what it means, the SE model could be misused as a pretext for privatisation and further cutbacks to the NHS. While the SE model (as implemented so far) has potential for producing significant improvements in the quality and equity of care, there is also a risk of its misuse by savvy operators who might use it to disguise attempts at privatisation. The vagueness and fuzziness of the term *SE* offers a warning against indiscriminate use of the model and suggests caution before it is rolled out more widely.

7.4 Policy Implications of Findings

In the Literature Review chapter (chapter 3), an overview was provided of the empirical research literature on the effects of market-inspired reforms of public healthcare provision on equity. It was shown that the existing empirical literature is divided on the subject and inconclusive. This research project aimed to contribute evidence to this discussion. This

project found no difference in the equity-supportiveness of the organizational cultures of public NHS and Social Enterprise healthcare providers. Therefore, this project can neither support further externalisation of NHS organizations as SEs nor argue against it. The question remains unresolved. However, the project does offer some evidence to suggest that the criticisms made of private, for-profit provision may apply with less force when the services are provided by SEs. Thus, SEs may provide an acceptable middle ground between fully publicly-owned, not-for-profit NHS provision and fully for-profit corporate private provision (such as Virgin Care, United Healthcare, Circle Holdings Plc., Serco, and Arriva).

What this project also shows is that being a public provider is not enough for providing an equitable service. A public organization can be poorly run, be financially undisciplined, and provide an inequitable service, as can a private organization. Healthcare professionals working in public organizations may claim that they treat everyone equally but they may not, in fact, treat everyone equally. Being a public body is not a panacea for the challenges facing healthcare provider organizations. In order to provide the most equitable service, good management and organization are equally important. The principal finding from this research project is that some Social Enterprises are demonstrating better management and organization than NHS organizations. The lesson, therefore, for NHS organizations is that they ought to learn from Social Enterprises and raise their standards.

The answer offered by this research project is not a simplistic one – that some SEs are providing better care than some public NHS organizations, therefore, the delivery of all care ought to be made through SEs. At the same time, this project does not suggest that provider organizations should remain public even if they provide shoddy care. The rather more complex answer emerging from this project is that organizational mission and values matter, therefore, being publicly-owned and accountable matter for equity. At the same time, sound management also matters equally for equity.

Political oversight expressed through strong regulation can help extract the best that SE and private provision has to offer while mitigating the risks to equity inherent in private provision. The effects of market-driven reforms on equity in service provision may be

mediated by political factors such as the extent of regulation of private providers. Political levers, therefore, have an important role to play in ensuring that the advantages of complementary SE and private provision can be realised while minimising their negative side-effects.

One of the ways in which political mechanisms can ensure that SE and private provision can be harnessed for the public good is by ensuring a truly level and fair playing field for both public and private providers. Pollock and Kirkwood (2009) argue for parity between public and private providers: they recommend that private healthcare providers should be required, like NHS providers, to collect and share data on their patients, staff and the quality of care they provide.

The Francis Report emphasized the need for building cultures of transparency, candour, openness and honesty and for sharing information on performance outcomes with the public to facilitate adequate scrutiny and accountability of care providers (Francis, 2013). The report was highly critical of the use of 'non-disparagement' and 'Gagging' clauses by the Care Quality Commission in its termination-of-employment contracts (the CQC placed an obligation of confidentiality on staff who were leaving the organization) (Francis, 2013; p. 1493). The report stated that 'the Inquiry has heard of the use by organisations of contractual terms to prevent or inhibit disclosure by employees or former employees of information critical of the organisation...Such clauses should be prohibited in the policies of all healthcare organisations, regulators and commissioners...Openness, transparency and candour are necessary attributes of organisations providing healthcare services to the public' (Francis, 2013; p. 1441, p. 1458, p. 1493).

The Francis Report was also clear about the necessity of ensuring that standards of care and management applied fairly and equally rigorously to both NHS and private providers. The report extended the requirement to practice NHS values to private providers to whom the provision of NHS services is outsourced. The report was firm in its stance that agreement by private providers to operate according to NHS values and principles be a condition of any outsourcing of contracts to them (Francis, 2013).

If SEs and other private providers wish to provide public services, they should be required to adhere to the same degree of transparency and sharing of information that public providers are subject to. Private firms should not get away with providing their employees unfair or exploitative employment terms and conditions. If that is how they deliver a cheaper service, they ought not to be entrusted with the delivery of a public service. Private and SE providers should agree to a common set of standards of care that apply equally to both private and NHS providers. They should accept the same regime of regulations, inspections and audits that the NHS does to ensure that standards of care are met. They should be willing to abide by Equalities and other relevant legislation which relate to the important values that underpin NHS provision. There should not be preferential treatment which disadvantages either party.

This requires NHS, SE and private providers to agree on the common aims, values and principles which must be observed in the provision of a publicly financed healthcare service. All parties need to agree to be bound by these common aims, values and principles. In their private capacity, private organizations can act as they please. But in their function as providers of a public service, they should be willing to adhere to the same constraints and obligations as public bodies do. At the same time, to ensure accountability, public providers such as the NHS ought to be subjected to the test of competition and if SE and private providers can offer a higher quality and more equitable service at the same or lower cost, they ought to be awarded the contract.

While advocating uniformity of standards and requirements, it is important to make a distinction between core and non-core aspects of service provision. The *core* aspects that need to apply equally to all providers of publicly financed care are the values and principles which the NHS stands for (and the legal infrastructure which supports these values – for example, the Equalities legislation which supports the core value of promoting equity in NHS provision). In the non-core aspects, such as in recruitment policies, computer systems, performance management practices, investment decisions, accounting systems, uniforms, etc., variability can be tolerated. What is non-core can change, and should be left to the specific provider organization to determine as it sees fit.

The main advantages of SEs seem to be those of independence and size. As independent organizations, they are no longer tied to NHS regulations and have the freedom to change procedures. Also, being small organizations, they have certain advantages (such as the accessibility of the leadership to the front-line and faster and smoother flow of information) which they did not have when they were under the NHS umbrella. It appears that the advantages offered by SE model (as exhibited by the ex-NHS healthcare providers examined in this project) are more those of autonomy, size, and better management than due to some unique advantage of the traditional SE model per se. Practices implemented by the ex-NHS SEs, for example, empowering front-line clinical staff, developing grass roots leadership, reducing bureaucracy, involving patients more - are attributes of good management in both public and private organizations (and not just in the healthcare sector). It is hard to argue that these practices are somehow exclusive to the SE model. It is more likely that they are simply instances of better management. Being freed from NHS control has perhaps enabled these SEs to adopt better management practices. The implication of this for NHS Trusts is that rushing to adopt a SE model may not be the only solution. It may be possible to remain within the public sphere and adopt sound management practices. It may require, however, that NHS Trusts be given the freedom to operate like independent units.

It is important to emphasize that the people who work in SEs are not greedy, ruthless profiteers concerned only about making a buck. They are compassionate, caring individuals who go out of their way to help their patients and service users. They are individuals who felt very frustrated and shackled by the bureaucracy of the NHS and prefer the freedom they have within a SE setup to use their initiative and implement their ideas which were being discouraged or not supported within the NHS.

It is argued by critics of privatisation that private healthcare provision tends to work to the disadvantage of the financially worse off who are unable to afford the market price of healthcare services. This research project did not find SEs discriminating against or acting in any way which was to the detriment of the financially worse off. As SEs provide NHS services that are publicly financed and free at the point of delivery, financial barriers did not

prevent the poor from obtaining healthcare from SE providers, nor was there any evidence to suggest that affluent patients received better care than relatively more deprived ones. SE staff currently operate under the ethos of equal treatment of all patients as they used to do in the NHS.

The successes of the first wave of Social Enterprise spin-outs from the NHS have created interest and appetite among acute NHS Trusts in adopting the SE model. Initial results from this research project indicate that Social Enterprises offer the potential for improving equity for patients. While this might be interpreted as grounds for encouraging their wider use in the provision of public health services, it should also be recognised that the SE model (currently limited to community healthcare services) remains unclear and problematic, suggesting caution in its use by larger NHS Trusts. More research is needed before a policy to support the use of SEs in public health provision can be considered to be based on firm evidence.

7.5 Strengths and Limitations of this Research Project

7.5.1 Strengths of this Research Project

In this section, the strengths of this research project are highlighted. The successes of this project are described.

1. This project extended earlier research comparing public and private provision of care to compare public (NHS) and hybrid (Social Enterprise) provision and contributed empirical evidence to an important national debate.

2. This was an innovative research project in that it applied the concept of organizational culture to equity and attempted to evaluate and compare organizational cultures in terms of

their supportiveness for equity. Few studies have attempted to compare the equity-supportiveness of organizational cultures in public and Social Enterprise healthcare providers. The unique angle taken by this project makes it a pioneering effort.

3. This research project included both quantitative (survey) and qualitative (in-depth interview) data in an attempt to compare and explain levels of equity in service provision. The use of mixed methods resulted in more in-depth analysis and richer findings.

4. The sample was a national one, with 21 healthcare providers (12 NHS Trusts and 9 SEs) spanning the length and breadth of England taking part in this project. A large number of healthcare professionals (n = 124) from a range of specialties (cardiac rehabilitation, stroke rehabilitation, Diabetes education, treatment and rehabilitation, smoking cessation, and alcohol support) took part in the survey and the interviews. This breadth and depth of coverage helped obtain a rich diversity of views and made its findings that much more reliable.

5. This project took a holistic view of organizational cultures and examined a number of systems that influence organizations' cultures such as mission, values, leadership, staff involvement in strategic decision-making, bureaucracy and speed of decision-making, service user involvement, innovation, and staff autonomy. The comprehensive coverage of organizational factors makes it one of the more thorough investigations of organizational cultures.

7.5.2 Limitations of this Research Project, and Recommendations for Future Research

In this section, the limitations of this research project as well as some of the lessons learnt are enumerated. Recommendations are made for future research that could build on and extend the work done in this project.

1. The analysis of levels of equity in service provision in (NHS) and hybrid (Social Enterprise) organizational cultures depends on self-reported perceptual data of staff working in these organizations. This data suffers from the problems of bias in subjective data and self-report data. Future research should compare Social Enterprises and NHS organizations using organizational performance data based on objective indicators of equity such as changes in equity of access, quality of care and health outcomes data (equity data before and after the change) for particular services. Also, this project did not obtain the views of service users. Their views are important in revealing whether equity has changed, and how. Future research should include the views of service users. This will help obtain a more holistic and accurate picture of the quality and equity of care that the two types of organizations are providing.

2. The concept of equity needs further refinement. Even now there seems to be some vagueness and a lack of clarity and concreteness in the understanding of this concept by healthcare practitioners. This makes it more difficult for researchers to evaluate the equity of services. It also increases the challenge for healthcare practitioners and managers to translate the findings of research into practical use to assess and improve the equity of services. Ways to capture the different dimensions of equity for particular services should be sought. Efforts need to be made to quantify levels of equity for particular health services and organizations to enable empirical observations and comparison and change over time. The clarification of the different dimensions of equity and their expression in quantitative terms and a comprehensive statement of the factors that affect equity (along with a clear elucidation of the causal chain and the pathways through which these factors affect equity) will enable empirical evidence-based policy instead of argumentation and rhetoric. Models of the organizational factors that impact on equity in service provision ought to be built. Future research should rely on more robust indicators of equity. Cookson et al. have devised indicators for measuring equity in a systematic and rigorous way. Their research should be incorporated in and built upon in future research.

3. The concept of organizational culture still continues to be arbitrarily and subjectively defined by different researchers. It also continues to be very broad in its scope. This affects

the usefulness of the findings for healthcare practitioners. Standardization of the 'organizational culture' construct and better operationalization is required. The focus of the construct might need to be narrowed and its boundaries delimited clearly. At present, it is not clear what it includes and what it excludes. Agreement is needed on a uniform application of the concept to different situations and settings. Also, there is a need for agreement on the best methods for examining organizational culture. This relates back to the conceptualisation of organizational culture. Too much diversity and choice in how to investigate organizational culture can reduce the comparability and, therefore, the usefulness of findings.

4. Each of the organizational factors examined in this project – organizational mission, values, leadership, performance management systems, innovation, or the use of technology – could be examined in depth. For example, considering the changes in innovation in the NHS and SEs and its impact on equity could become the basis for a small research project in its own right. Similarly, instead of overall equity, a specific equity issue – socio-economic equity (the most common type), gender equity, ethnic equity, sexual equity, etc. – could be made the focus of a research project.

5. Only the views of SE staff were elicited in the interviews. Perhaps, the views of NHS staff, especially, those working in the Equalities Teams in NHS Trusts ought to have been requested. Their input could also have been usefully obtained at the pilot stage in designing the questionnaire and interview schedule.

6. The survey was very long and wordy. The high number of incomplete responses suggests that the survey ought to have been shorter, simpler, and less wordy. This would have helped reduce the wastage of potential responses (and the valuable time of respondents).

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Appendix 1: Organizational Equity Culture Assessment Survey

Introduction

Aim of the Research: The aim of this research project is to compare organizational cultures in *public* (for example, NHS) and *hybrid* health care organizations (such as social enterprises) in relation to promoting equity. This research is trying to find out whether an organization's

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form as *public* or *hybrid* is related to, or affects, its culture around promoting equity in health care provision. In other words, this project aims to know whether *public* healthcare organizations like the NHS have cultures and working practices that are equally supportive of equity as *hybrid* healthcare organizations like social enterprises.

Culture: Culture is a complex and disputed concept, but according to one widely-used definition, it is a pattern of shared beliefs, developed by a given group as it learns to cope with its problems, that has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to think and feel.

Equity: Equity is about how fairly health resources and opportunities are distributed throughout a group of people. A fair distribution of resources and opportunities is one based on need. Equity can be explained as: a) equal access to care, or equal use, for equal need, b) equal quality of care for equal need, and c) equal health outcomes for equal need.

Equity means that there shouldn't be any unfair differences in access, quality of care or health outcomes between sub-groups of the population on the basis of socio-economic status, age, gender, ethnicity, disability, sexual orientation, etc.

Equity means ensuring that health care services for disadvantaged groups are not of poorer quality or less accessible; that the allocation of resources is in relation to need; and that extra efforts are made to reach those whose health is worse.

Participant Information Sheet

Title of Research Project: A Comparison of Organizational Cultures around Promoting Equity in Public and Hybrid Healthcare Organizations

I would like to invite you to take part in this research project. This page gives you more

information about the project. Please read it carefully before deciding whether to take part or not. Please ask me if anything is not clear. Thank you for reading this.

What is the purpose of this research study?

My name is Ashok Patnaik. I am a doctoral research student in the School of Human and Health Sciences at the University of Huddersfield. I am conducting this research project as part of the requirements of my Doctor of Philosophy degree in Health Policy. This project is being sponsored and funded by the University of Huddersfield.

The aim of this research project is to compare organizational cultures in *public* (for example, NHS) and *hybrid* health care organizations (such as social enterprises) in relation to promoting equity. This research is trying to find out whether an organization's form as *public* or *hybrid* is related to, or affects, its culture around promoting equity in health care provision. In other words, this project aims to know whether *public* healthcare organizations like the NHS have cultures and working practices that are equally supportive of equity as *hybrid* healthcare organizations like social enterprises.

Why have I been chosen?

As you are an employee of a participating public or hybrid health care organization, and are knowledgeable about its work culture and equity-related performance, I would like to invite you to participate.

Do I have to take part?

No. Your participation is completely voluntary. You do not have to take part in this study if you do not want to. If you choose to participate and then change your mind, you may leave the study at any time for any reason by letting me know. If you withdraw, any information contributed until the time of withdrawal will be included in the study but no more information will be collected from you from that point on.

What will happen to me if I take part?

If you decide to participate, you will be given this information sheet to keep and be asked to agree to a consent form. You may be asked to complete a questionnaire. The questionnaire will take about 10 to 15 minutes to complete. The survey will ask you questions about different aspects of your organization's work culture such as staff involvement in decision-making, the role of leadership, performance targets, etc. and how supportive they are of equity. The survey will be online; the link will be sent to your work email address.

What are the possible benefits of taking part?

I hope that the findings from this study will yield a clearer understanding of how organizational factors such as an organization's form (public or hybrid) might affect its culture in relation to promoting equity. If your organization has an explicit goal of promoting equity, it might be useful for you to know about the cultural factors that affect an organization's equity performance. Although no compensation will be offered, a copy of the research report will be held in the University Repository, and will be accessible to participating organizations or individual research participants.

What are the possible disadvantages and risks of taking part?

There are no major anticipated risks or disadvantages resulting from participation in this study. It is possible that you may feel uneasy in answering some of the questions. You do not have to answer any questions you do not wish to.

Will my information be kept confidential?

All information obtained during this study will be treated in the strictest confidence. Any information collected during this study will be seen only by me and the supervisors of the study, Dr. John Stephenson and Dr. Jamie Halsall. Information will be stored and analyzed in secure conditions at my office and those of the supervisors at the University of Huddersfield.

Your name or the name of your organization will not appear in any publication resulting from this study.

What if something goes wrong?

If you have any concerns about this study and wish to make a complaint, please contact me at the telephone number or email address given below. If you remain dissatisfied and wish to make a more formal complaint, please contact the academic supervisor of the study, Dr. John Stephenson (contact details are given below).

What will happen to the information I have provided?

The information collected during this study will be kept for 5 years in secure conditions at the University of Huddersfield and, then, destroyed. The information collected may be used in anonymised form for additional research.

What will happen to the results of the study?

The results of the study may be published in my doctoral dissertation and in academic journal articles, and be presented at conferences, seminars, etc. Further, a copy of the dissertation will be held in the University Repository and may be consulted by other researchers in the field.

Thank you very much for reading this information sheet. If you would like to participate, or would like additional information to assist you in reaching a decision about participation, please contact me at the telephone number or email address listed below.

I hope that you will agree to take part in this project. May I thank you in advance for your assistance in this research project?

This study has been reviewed and has received ethical approval from the University of Huddersfield School of Human and Health Sciences Research Ethics Committee (SREP).

Responses to the survey will be completely anonymous. It will not be possible to identify any individual from the responses because of the large sample size, consisting of a number of individuals sampled from each of around 30 NHS Trusts and 20 social enterprises, and the nature of the online survey data collection process (responses from all the organizations in the study will be pooled at one site without being classified by organization). The organizations (Trusts and social enterprises) will never have access to the responses.

For further information on any aspect of the project, please contact:

Researcher Name: Ashok Patnaik
Telephone number: 07527903126
Email address: U1076568@hud.ac.uk

Academic Supervisor Name: Dr. John Stephenson
Telephone number: 01484 471513
Email address: j.stephenson@hud.ac.uk

Consent Form

Title of Research Project: A Comparison of Organizational Cultures around Promoting Equity in Public and Hybrid Healthcare Organizations

Name of Researcher: Ashok Patnaik

It is important that you read, understand and agree to this consent form. Your contribution to

this research is entirely voluntary and you are not obliged in any way to participate. If you require any further details, please contact the researcher.

If you are satisfied that you understand the information and are happy to take part in this study, please circle the 'Yes' option after each sentence. Please make sure you have responded to all the statements on this page before you proceed to the survey.

If you disagree with any of the statements, or do not wish to respond with 'Yes', please contact the researcher to discuss your participation in the project. The researcher's contact details follow.

Researcher Name: Ashok Patnaik
Telephone number: 07527903126
Email address: U1076568@hud.ac.uk

1. I confirm that I have read and understood the information sheet for the abovementioned study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

Yes

2. I have been fully informed of the nature and aims of this research.

Yes

3. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason or without being affected in any way.

Yes

4. I agree to take part in the abovementioned study.

Yes

5. I give permission for my words to be quoted (a pseudonym will be used).

 Yes

6. I understand that the information collected will be kept in secure conditions for a period of five years at the University of Huddersfield.

Yes

7. I understand that no person other than the researcher and the supervisors of the project will have access to the information provided.

Yes

8. I understand that during the study my identity will be protected by the use of pseudonyms. No information that could lead to my being identified will be included in any report resulting from this study. All data collected during the study will be anonymised at the end of the study.

Yes

Instructions

You will be asked questions about different aspects of your organization's work culture such as staff involvement in decision-making, the role of leadership, performance targets, etc. and how supportive they are of equity. The questionnaire will take about 10 to 15 minutes of your time.

This survey asks you to evaluate your current organization as it actually exists. You should

base your responses on the way your organization actually is at present - not how it aspires to be or the way you think it ideally should be.

Please be aware that some of the questions may appear to have a slant towards management; they are not meant to do. All the questions are intended to be answered by clinical and non-clinical staff alike. The questions are about your experience of working in an NHS Trust or a social enterprise, and about its work culture around promoting equity. So, please answer the questions from your experience of working in an NHS Trust or a social enterprise. If some of the questions are outside your area of expertise or knowledge, please say 'Don't Know'.

Please note that only fully completed surveys can be accepted. To make sure that your valuable responses are received, please do work through the survey till the end.

Responses to the survey will be completely anonymous. It will not be possible to identify any individual from the responses because of the large sample size, consisting of a number of individuals sampled from each of around 30 NHS Trusts and 20 social enterprises, and the nature of the online survey data collection process (responses from all the organizations in the study will be pooled at one site without being classified by organization). The organizations (Trusts and social enterprises) will never have access to the responses.

Organizational Equity Culture Assessment Survey

Section 1

Instructions

Please circle the relevant option to select it.

If you don't know, or do not wish to answer the question for any other reason (for example, if you do not feel comfortable answering the question), please select the *Don't Know* option.

1. Does the organisation have an explicit strategy or plan to promote equity in the provision of care?

Yes.

No.

Don't Know.

2. Do performance management processes take into consideration the promotion of equity in the provision of care (i.e., are financial incentives, recognition, etc. linked to the promotion of equity)?

Yes.

No.

Don't Know.

3. Is there a clear assignment of responsibility in the organization for the promotion of equity in the provision of care?

Yes.

No.

Don't Know.

4. Do the organisation's induction and training programs educate staff on equity-related issues?

Yes.

No.

Don't Know.

5. Can equity-related issues be raised easily by staff?

Yes.

No.

Don't Know.

6. Is the promotion of equity in the provision of care a formal board responsibility?

Yes.

No.

Don't Know.

7. Is the promotion of equity in the provision of care a part of the contractual agreement with commissioners or funders?

Yes.

No.

Don't Know.

Section 2

Instructions

Please circle the relevant option to select it.

If you don't know, or do not wish to answer the question for any other reason (for example, if you do not feel comfortable answering the question), please select the *Don't know* option.

8a. Is data on equity collected routinely (for example, patient admission data or service user data on socio-economic status, age, gender, ethnicity, sexual orientation, disability, etc.)?

Yes.

No.

Don't Know.

8b. If yes, on which dimensions is data recorded? (select all that apply)

Socio-economic status

Age

Gender

Ethnicity

Sexual orientation

Disability

Don't know

9. Is equity in the provision of care measured from the available raw data?

Yes.

No.

Don't Know.

10. Is equity data used on an ongoing basis to monitor changes in the organization's equity outcomes?

Yes.

No.

Don't Know.

11. Is equity data used to make changes in the organization of services to improve the organization's equity outcomes?

Yes.

No.

Don't Know.

12. Is equity data used to make changes in the delivery of services to improve the organization's equity outcomes?

Yes.

No.

Don't Know.

13a. Is a Health Equity Audit (or a similar exercise) performed for your unit / service?

Health Equity Audit is a process in which health care organizations examine inequities in the causes of ill health, and access to health services and their outcomes, for a defined health service or population. Following the review, they agree on actions to take to reduce inequities, for example, by making changes in resource allocation, commissioning, service planning, and delivery. Finally, they check whether their actions have been effective and whether inequities have been reduced.

Yes.

No.

Don't Know.

13b. If yes, how often are Health Equity Audits (or similar exercises) performed for your unit / service?

Once a year

Once every 2 years

Once every 3 years

Once every 4 years

Even less frequently

Don't know

Section 3

Instructions

Please circle the relevant option on the line below to select it.

14. How much importance do clinicians in the organization give to the promotion of equity in the provision of care? Please select an option from the list of options below to indicate the degree of importance given by clinicians to the promotion of equity in the provision of care (please circle the relevant option on the line below). The options represent a linear scale.
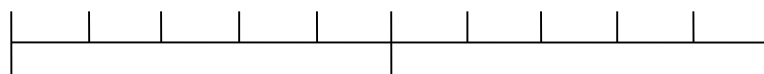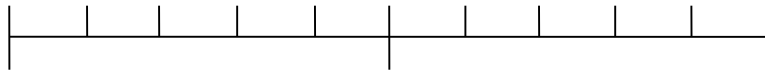
Extremely Unimportant = 0   Extremely Important = 10

If you don't know, or do not wish to answer, please indicate by placing a cross in the box.

15. How much importance do management in the organization give to the promotion of equity in the provision of care? Please select an option from the list of options below to indicate the degree of importance given by management to the promotion of equity in the provision of care (please circle the relevant option on the line below). The options represent a linear scale.
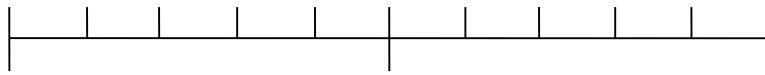
Extremely Unimportant = 0   Extremely Important = 10

If you don't know, or do not wish to answer, please indicate by placing a cross in the box.

16. How much importance do allied health professionals in the organization give to the promotion of equity in the provision of care? Please select an option from the list of options below to indicate the degree of importance given by allied health professionals to the promotion of equity in the provision of care (please circle the relevant option on the line below). The options represent a linear scale.

Extremely Unimportant = 0   Extremely Important = 10

If you don't know, or do not wish to answer, please indicate by placing a cross in the box.

17. How much importance do administrative staff in the organization give to the promotion of equity in the provision of care? Please select an option from the list of options below to indicate the degree of importance given by administrative staff to the promotion of equity in the provision of care (please circle the relevant option on the line below). The options represent a linear scale.

Extremely Unimportant = 0   Extremely Important = 10

If you don't know, or do not wish to answer, please indicate by placing a cross in the box.

Section 4

Instructions

Please circle the relevant option to select it.

If you don't know, or do not wish to answer the question for any other reason (for example, if you do not feel comfortable answering the question), please select the *Don't know* option.

18. Do equity considerations play a role in the allocation of resources (human, financial, infrastructural)?

Yes.

No.

Don't Know.

19. Please select an option from the list of options below to indicate how important equity considerations are in the allocation of resources. The options represent a linear scale.
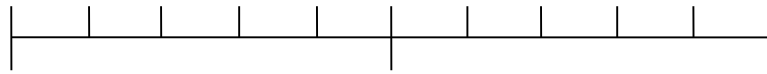
Extremely Unimportant = 0   Extremely Important = 10

If you don't know, or do not wish to answer, please indicate by placing a cross in the box.

20. Do equity considerations play a role in planning the organization of services?

Yes.

No.

Don't Know.

21. Please select an option from the list of options below to indicate how important equity considerations are in planning the organization of services. The options represent a linear scale.

Extremely Unimportant = 0   Extremely Important = 10

If you don't know, or do not wish to answer, please indicate by placing a cross in the box.
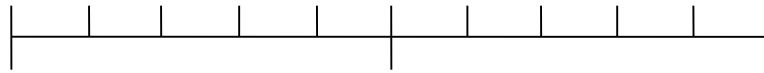
22. Do equity considerations play a role in planning the delivery of services?

Yes.

No.

Don't Know.

23. Please select an option from the list of options below to indicate how important equity considerations are in planning the delivery of services. The options represent a linear scale.

Extremely Unimportant = 0   Extremely Important = 10

If you don't know, or do not wish to answer, please indicate by placing a cross in the box.

Section 5

Instructions

Please circle the relevant option on the line below to select it.

24. **Individual Performance Targets**

Think about the targets that are used to assess your individual performance.

Think about how supportive or unsupportive your individual performance targets are of equity, i.e., whether they make you act in ways that increase equity or reduce it. For example, if your individual performance targets are supportive of equity, expectations of advancing equity will be a part of routine targets and performance management processes; recognition, financial incentives, etc. will be linked to the advancement of equity.

Please select an option from the list of options below to indicate how supportive or unsupportive your individual performance targets are of equity. The options represent a linear scale.
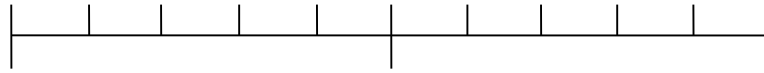
Extremely Unsupportive
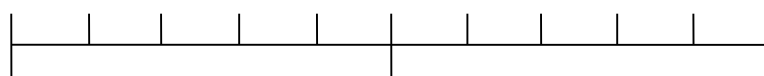of Equity = 0

Extremely Supportive
of Equity = 10

If you don't know, or do not wish to answer, please indicate by placing a cross in the box.

25. **Role of Immediate Leadership**

Think about the role of your immediate leadership (the leadership in your department, unit or ward) in creating an environment within the unit which is supportive of, and promotes, equity (for example, by setting out clear expectations of standards, communicating values, monitoring performance, coaching and supporting, etc.).

Think about how supportive or unsupportive the role of your immediate leadership is of equity, i.e., whether it makes you act in ways that increase equity or reduce it. For example, if your immediate leadership is supportive of equity, they will set the right example by demonstrating equitable care in their interactions with patients; they will support your equitable decisions; they will correct your inequitable actions and mistakes and advise you on how to be more equitable.

Please select an option from the list of options below to indicate how supportive or unsupportive the role of your immediate leadership is of equity. The options represent a linear scale.

Extremely Unsupportive

Extremely Supportive

of Equity = 0   of Equity = 10

If you don't know, or do not wish to answer, please indicate by placing a cross in the box.

26. **Role of Leadership by the Organization's Top Management**

Think about the role of leadership by your organization's top management in creating an environment within the organization which is supportive of, and promotes, equity (for example, by showing a commitment to equity, giving priority to equity, articulating and mobilising a clear philosophy of equity, providing resources and training, listening and responding to staff concerns and opinions about equity, etc.).

Think about how supportive or unsupportive the role of leadership by your organization's top management is of equity, i.e., whether it makes you act in ways that increase equity or reduce it. For example, if your top leadership is supportive of equity, they will create a dedicated, high-level task force to drive equity initiatives and take responsibility for equity-related issues; they will set aside adequate resources specifically for initiatives that advance equity; and they will support equity-relevant data collection and research.

Please select an option from the list of options below to indicate how supportive or unsupportive the role of leadership by your organization's top management is of equity. The options represent a linear scale.

Extremely Unsupportive   Extremely Supportive
of Equity = 0   of Equity = 10
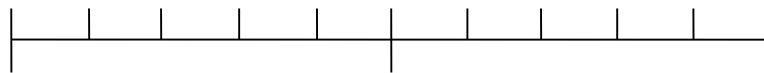
If you don't know, or do not wish to answer, please indicate by placing a cross in the box.

27. **Extent of Involvement in Strategic Decision-making**

Think about how involved you are in making important organizational decisions. An important or strategic decision is one about the long-term direction, goals, or values of the organization, or about appropriate ways to invest significant financial and human resources.

Think about how supportive or unsupportive the extent of your involvement in strategic decision-making is of equity, i.e., whether it makes you act in ways that increase equity or reduce it. For example, if your organization is supportive of equity, it will give members of staff at all levels a say in important organizational decisions that affect them. As an instance, one health care organization has members of staff, service users and carers on its board and they have equal voting rights.

Please select an option from the list of options below to indicate how supportive or unsupportive the extent of your involvement in strategic decision-making is of equity. The options represent a linear scale.

|├───┼───┼───┼───┼───┼───┼───┼───┼───┼───┤|

Extremely Unsupportive
of Equity = 0

Extremely Supportive
of Equity = 10

If you don't know, or do not wish to answer, please indicate by placing a cross in the box.

28. **Ease of Decision-making**

Think about how easy or difficult it is to make important decisions in your organization (does a decision require approval from a number of people; does it require a lot of paperwork; does it take a long time). An important decision is one that affects the organization and the way health services are delivered (it is not merely a personal decision) and involves some kind of change or deviation from established procedures or practice.

Think about how supportive or unsupportive the ease of decision-making in your organization is of equity, i.e., whether it makes you act in ways that increase equity or reduce it. For example, if the decision-making process is supportive of equity, it will be possible to make decisions that advance equity easily and quickly.

Please select an option from the list of options below to indicate how supportive or unsupportive the ease of decision-making in your organization is of equity. The options represent a linear scale.

Extremely Unsupportive
of Equity = 0
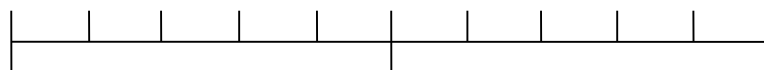
Extremely Supportive
of Equity= 10

If you don't know, or do not wish to answer, please indicate by placing a cross in the box.

29. **Amount of Autonomy**

Think about the amount of autonomy you have over your work and how you do it (how much freedom you have to make decisions on your own; how much control you have over your work; how much influence you have to shape the way services are delivered).

Think about how supportive or unsupportive the amount of autonomy you have is of equity, i.e., whether it makes you act in ways that increase equity or reduce it. For example, if the amount of autonomy you have is supportive of equity, you will have the freedom and the power to tailor services to respond in a sensitive and equitable manner to the individual needs and preferences of patients.

Please select an option from the list of options below to indicate how supportive or unsupportive the amount of autonomy you have is of equity. The options represent a linear scale.

460

Extremely Unsupportive

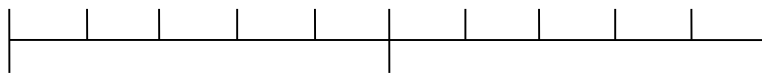of Equity $= 0$

Extremely Supportive

of Equity $= 10$

If you don't know, or do not wish to answer, please indicate by placing a cross in the box.

30. **Organizational Mission**

Think about the mission of your organization. An organization's mission is its core purpose or ultimate function in society, the most important reason for its existence. For example, the mission of one health care organization is to provide safe, patient-focused and sustainable health services.

Think about how supportive or unsupportive your organization's mission is of equity, i.e., whether it makes you act in ways that increase equity or reduce it. For example, if your organization's mission is supportive of equity, your organization will collect equity data methodically and comprehensively; it will monitor changes in the organization's equity outcomes; it will use the equity data to make changes in the way services are planned, organized, and delivered to improve the organization's equity outcomes.

Please select an option from the list of options below to indicate how supportive or unsupportive your organization's mission is of equity. The options represent a linear scale.

Extremely Unsupportive
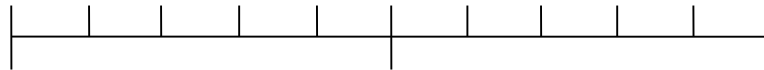
of Equity $= 0$

Extremely Supportive

of Equity $= 10$

If you don't know, or do not wish to answer, please indicate by placing a cross in the box.

31. **Organizational Goals**

Think about the goals of your organization. An organization's goals are the specific, concrete aims that the organization is trying to achieve. For example, one health care organization has three main goals: reducing health inequalities, improving quality of services and increasing productivity of staff.

Think about how supportive or unsupportive your organization's goals are of equity, i.e., whether they make you act in ways that increase equity or reduce it. For example, if your organization's goals are supportive of equity, your organization will have explicit and clear equity targets; it will report publicly regularly on progress towards its equity targets; it will include equity targets in contracts with service providers; it will use financial and other incentives to encourage service providers to achieve their equity targets.

Please select an option from the list of options below to indicate how supportive or unsupportive your organization's goals are of equity. The options represent a linear scale.

Extremely Unsupportive
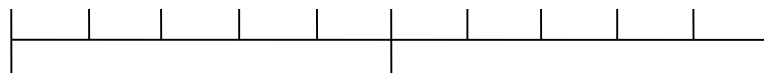of Equity = 0

Extremely Supportive
of Equity = 10

If you don't know, or do not wish to answer, please indicate by placing a cross in the box.

32. **Organizational Values**

Organizational values are about the kinds of behaviour that an organization values in its employees. For example, acting with compassion and behaving ethically are common values for many healthcare organizations. Values are the kinds of behaviour that are *actually* valued and practiced. In an organization that truly values honesty and openness, admission of mistakes or below-standard care is encouraged; if admission of mistakes and concerns about quality of care is discouraged, then, honesty and openness are not the organization's true values.

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Think about how supportive or unsupportive your organization's values are of equity, i.e., whether they make you act in ways that increase equity or reduce it. For example, if your organization's values are supportive of equity, your organization will make equity essential to all recruitment, promotion and retention decisions; it will educate all staff on equity-related issues and train them to be sensitive to differences of culture, gender, class, religion, etc.

Please select an option from the list of options below to indicate how supportive or unsupportive your organization's values are of equity. The options represent a linear scale.

Extremely Unsupportive
of Equity = 0

Extremely Supportive
of Equity = 10

If you don't know, or do not wish to answer, please indicate by placing a cross in the box.

Instructions

If you don't know, or do not wish to answer the question for any other reason (for example, if you do not feel comfortable answering the question), please skip the question and go to the next page.

33. **Relative Importance of Different Cultural Categories**

The different cultural categories such as involvement in decision-making, the role of leadership, performance targets, etc. may differ in their importance in affecting the equity culture in your organization. Please assess their relative importance by giving a score between 0 and 10 to the different cultural categories.

Please note that there are 9 cultural categories to score. A category of average importance in influencing the equity culture in your organization should be given 5 points. A category of

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more than average importance should be given more than 5 points. A category of less than average importance should be given less than 5 points.

Extreme scores are acceptable. You can give a zero score to a category or to categories.

Cultural Category	Points
Individual performance targets	
Role of immediate leadership	
Role of leadership by the top management	
Extent of involvement in strategic decision-making	
Ease of decision-making	
Amount of autonomy	
Organizational mission	
Organizational goals	
Organizational values	

Section 6

Demographic Questions:

Instructions

Please circle the relevant option to select it.

If you don't know, or do not wish to answer the question for any other reason (for example, if you do not feel comfortable answering the question), please skip the question and go to the next one.

Professional:

34. Professional role / Job Title:

35. Clinical department / specialism:

36. Role (select all that apply):

Clinical

Managerial

Administrative

I do not wish to disclose this information

37. Level of care at which you work (primary / secondary / tertiary): (select all that apply)

Primary

Secondary

Tertiary

I do not wish to disclose this information.

38. Length of employment with the organization (years and months):

39. Departmental tenure: the length of time for which you have worked in your present department (years and months):

Organizational:

40. What type of health care organization do you work in?

The National Health Service (NHS)

A Social Enterprise

Other (please specify)

41. Level of care provided by the organization (primary / secondary / tertiary): (select all that apply)

Primary

Secondary

Tertiary

I do not wish to disclose this information

Personal:

42. Age:

43. Gender:

Male

Female

Other (please specify)

I do not wish to disclose this information

44. Ethnicity:

45. Disability: Do you consider yourself to have a disability?

Yes

No

I do not wish to disclose this information

If yes, please state the nature of your disability:

46. Level of education (the highest educational qualification that you have achieved):

47. Political values: Where would you place yourself on the political spectrum (left, right, centre)?

Please select an option from the list of options below to indicate where you would place yourself on the political spectrum. The options represent a linear scale.
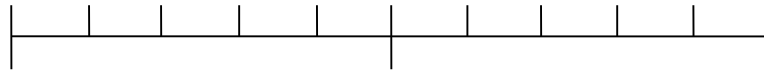
The Political Left = 0   The Political Right = 10

If you don't know, or do not wish to answer, please indicate by placing a cross in the box.

48. **Additional Information**:

If you would like to add any comments or information, please do so in the space below.

Thank you very much for sparing your precious time to complete this survey. Your response is received gratefully.

Appendix 2: Interview Schedule

Aim of the Research: The aim of this research project is to compare organizational cultures in *public* (for example, NHS) and *hybrid* health care organizations (such as social enterprises) in relation to promoting equity. This research is trying to find out whether an organization's form as *public* or *hybrid* is related to, or affects, its culture around promoting equity in health care provision. In other words, this project aims to know whether *public* healthcare

organizations like the NHS have cultures and working practices that are equally supportive of equity as *hybrid* healthcare organizations like social enterprises.

Culture: Culture is a complex and disputed concept, but according to one widely-used definition, it is a pattern of shared beliefs, developed by a given group as it learns to cope with its problems, that has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to think and feel.

Equity: Equity is about how fairly health resources and opportunities are distributed throughout a group of people. A fair distribution of resources and opportunities is one based on need. Equity can be explained as: a) equal access to care, or equal use, for equal need, b) equal quality of care for equal need, and c) equal health outcomes for equal need.

Equity means that there shouldn't be any unfair differences in access, quality of care or health outcomes between sub-groups of the population on the basis of socio-economic status, age, gender, ethnicity, disability, sexual orientation, etc.

Equity means ensuring that health care services for disadvantaged groups are not of poorer quality or less accessible; that the allocation of resources is in relation to need; and that extra efforts are made to reach those whose health is worse.

Questions

1. What, in your view, is the mission of your organization? An organization's mission is its core purpose or ultimate function in society, the most important reason for its existence. For example, the mission of one health care organization is to provide safe, patient-focused and sustainable health services.

An organization's mission can have an impact on its efforts to promote equity. For example, if an organization's mission is supportive of equity, the organization will collect equity data methodically and comprehensively; it will monitor changes in the organization's equity

outcomes; it will use the equity data to make changes in the way services are planned, organized, and delivered to improve the organization's equity outcomes.

Has your organization's mission changed since it left the NHS and became a social enterprise? What was the old organizational mission? What is the (potentially) new organizational mission?

Has the (potentially) new (or changed) mission led your organization to become more or less equitable in the way it delivers services? If so, how? Can you give me some specific examples?

2. What, in your view, are the goals of your organization? An organization's goals are the specific, concrete aims that the organization is trying to achieve. For example, one health care organization has three main goals: reducing health inequalities, improving quality of services and increasing productivity of staff.

An organization's goals can have an impact on its efforts to promote equity. For example, if an organization's goals are supportive of equity, the organization will have explicit and clear equity targets; it will report publicly regularly on progress towards its equity targets; it will include equity targets in contracts with service providers; it will use financial and other incentives to encourage service providers to achieve their equity targets.

Have your organization's goals changed since it left the NHS and became a social enterprise? What were the old organizational goals? What are the (potentially) new goals?

Have the (potentially) new (or changed) goals led your organization to become more or less equitable in the way it delivers services? If so, how? Can you give me some specific examples?

3. What, in your view, are the values of your organization? Organizational values are about the kinds of behaviour that an organization values in its employees. For example, acting with compassion and behaving ethically are common values for many healthcare organizations. Values are the kinds of behaviour that are *actually* valued and practiced. In an organization that truly values honesty and openness, admission of mistakes or below-standard care is

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encouraged; if admission of mistakes and concerns about quality of care is discouraged, then, honesty and openness are not the organization's true values.

An organization's values can have an impact on its efforts to promote equity. For example, if an organization's values are supportive of equity, the organization will make equity essential to all recruitment, promotion and retention decisions; it will educate all staff on equity-related issues and train them to be sensitive to differences of culture, gender, class, religion, etc.

Have your organization's values changed since it left the NHS and became a social enterprise? What were the old organizational values? What are the (potentially) new organizational values?

Have the (potentially) new (or changed) values led your organization to become more or less equitable in the way it delivers services? If so, how? Can you give me some specific examples?

4. What are the targets that are used to assess your individual performance?

An individual's performance targets can have an impact on their efforts to promote equity. For example, if an individual's performance targets are supportive of equity, expectations of advancing equity will be a part of routine targets and performance management processes; recognition, financial incentives, etc. will be linked to the advancement of equity.

Have your individual performance targets changed since your organization left the NHS and became a social enterprise? What were the old individual performance targets? What are the (potentially) new individual performance targets?

Have the (potentially) new individual performance targets led your organization to become more or less equitable in the way it delivers services? If so, how? Can you give me some specific examples?

5A. What, in your view, is the role of your immediate leadership (the leadership in your department, unit or ward) in creating an environment within the unit which is supportive of, and promotes, equity (for example, by setting out clear expectations of standards, communicating values, monitoring performance, coaching and supporting, etc.)?

The role of the immediate leadership can have an impact on departmental staff members' efforts to promote equity. For example, if the immediate leadership is supportive of equity, they will set the right example by demonstrating equitable care in their interactions with patients; they will support your equitable decisions; they will correct your inequitable actions and mistakes and advise you on how to be more equitable.

Has the role of your immediate leadership changed since your organization left the NHS and became a social enterprise? What was the role of your immediate leadership in the old organization? What is the role of your immediate leadership in the new organization?

Has the (potentially) new (or changed) role of your immediate leadership led your organization to become more or less equitable in the way it delivers services? If so, how? Can you give me some specific examples?

5B. What, in your view, is the role of leadership by your organization's top management in creating an environment within the organization which is supportive of, and promotes, equity (for example, by showing a commitment to equity, giving priority to equity, articulating and mobilising a clear philosophy of equity, providing resources and training, listening and responding to staff concerns and opinions, etc.)?

The role of leadership by the organization's top management can have an impact on staff members' efforts to promote equity. For example, if the top leadership is supportive of equity, they will create a dedicated, high-level task force to drive equity initiatives and take responsibility for equity-related issues; they will set aside adequate resources specifically for initiatives that advance equity; and they will support equity-relevant data collection and research.

Has the role of leadership by your organization's top management changed since your organization left the NHS and became a social enterprise? What was the role of leadership by your organization's top management in the old organization? What is the role of leadership by your organization's top management in the new organization?

Has the (potentially) new (or changed) role of leadership by your organization's top management led your organization to become more or less equitable in the way it delivers services? If so, how? Can you give me some specific examples?

6. How involved are you in making important decisions in your organization? An important or strategic decision is one about the long-term direction, goals, or values of the organization, or about appropriate ways to invest significant financial and human resources.

The extent of involvement in the making of strategic decisions offered to members of staff can have an impact on their efforts to promote equity. For example, if an organization is supportive of equity, it will give members of staff at all levels a say in important organizational decisions that affect them. As an instance, one health care organization has members of staff, service users and carers on its board and they have equal voting rights.

Has the extent of your involvement in the making of important organizational decisions changed since your organization left the NHS and became a social enterprise? How involved were you earlier? How involved are you now?

Has the (potentially) new extent of your involvement in the making of strategic decisions led your organization to become more or less equitable in the way it delivers services? If so, how? Can you give me some specific examples?

7. How easy or difficult is it to make important decisions in your organization (does a decision require approval from a number of people; does it require a lot of paperwork; does it take a long time)? An important decision is one that affects the organization and the way health services are delivered (it is not merely a personal decision) and involves some kind of change or deviation from established procedures or practice.

The ease of making important decisions can have an impact on staff members' efforts to promote equity. For example, if the decision-making process is supportive of equity, it will be possible to make decisions that advance equity easily and quickly.

Has the ease (or difficulty) of making decisions changed since your organization left the NHS and became a social enterprise? How easy (or difficult) was it earlier? How easy (or difficult) is it now?

Has the (potentially) greater ease (or difficulty) of making decisions led your organization to become more or less equitable in the way it delivers services? If so, how? Can you give me some specific examples?

8. How much autonomy do you have over your work and how you do it (how much freedom you have to make decisions on your own; how much control you have over your work; and how much influence you have to shape the way services are delivered)?

The amount of autonomy allowed by the organization to members of staff can have an impact on their efforts to promote equity. For example, if the organization is supportive of equity, members of staff will have the freedom and the power to tailor services to respond in a sensitive and equitable manner to the individual needs and preferences of patients.

Has the amount of autonomy you have changed since your organization left the NHS and became a social enterprise? How much autonomy did you have earlier? How much autonomy do you have now?

Has the (potential) change in the amount of autonomy you have led your organization to become more or less equitable in the way it delivers services? If so, how? Can you give me some specific examples?